

Introduction to Medicaid

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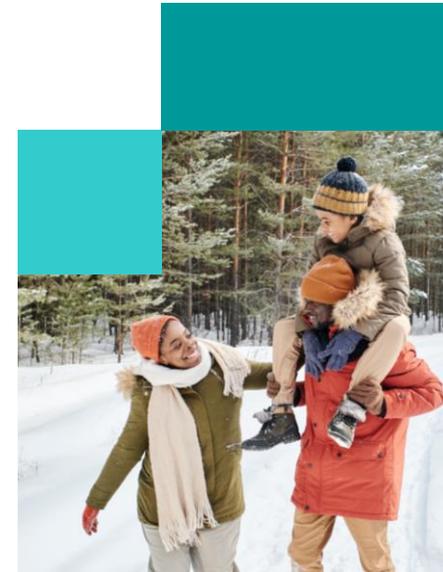
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February 3, 2025



Department of
**HEALTH &
HUMAN SERVICES**



Agenda

Part 1: What is Medicaid?

- What is Medicare?
- Medicaid & the DHHS Roadmap: How Medicaid Supports All Programs

Part 2: Eligibility & Enrollment

Part 3: Medicaid Coverable Services (Mandatory and Optional)

Part 4: Key Financing Issues

- Budget Driver in the Managed Care Program

Part 5: Medicaid Provider/Service Payment Fundamentals

- How does Medicaid Partner with other DHHS Program Area Divisions
- The Fundamentals of Medicaid State Plans and Waivers
- What It Takes to Make a Waiver Successful

Epilogue: Risk of Federal Changes to the Federal Financing of Medicaid



Part 1:

What is Medicaid?





What is Medicaid?

“If you’ve seen one Medicaid Program, then you’ve seen one Medicaid program”

- **Public health benefit program for low-income individuals and families, including children, pregnant women, parents, elderly individuals with certain low-incomes, individuals with disabilities, and individuals receiving supplemental social security**
- **Financed through a federal-state partnership, and administered by the states**
- **Each state designs and operates its own program within broad federal guidelines**
- **Created in 1965 as Title XIX of the Social Security Act**



Push-pull of federal authority and states’ rights — since the start of US government



Federal government pays at least half the national cost of Medicaid = serious influence over program



State plan amendments (SPAs) and waivers are used by states to get federal approval to make changes to their Medicaid program

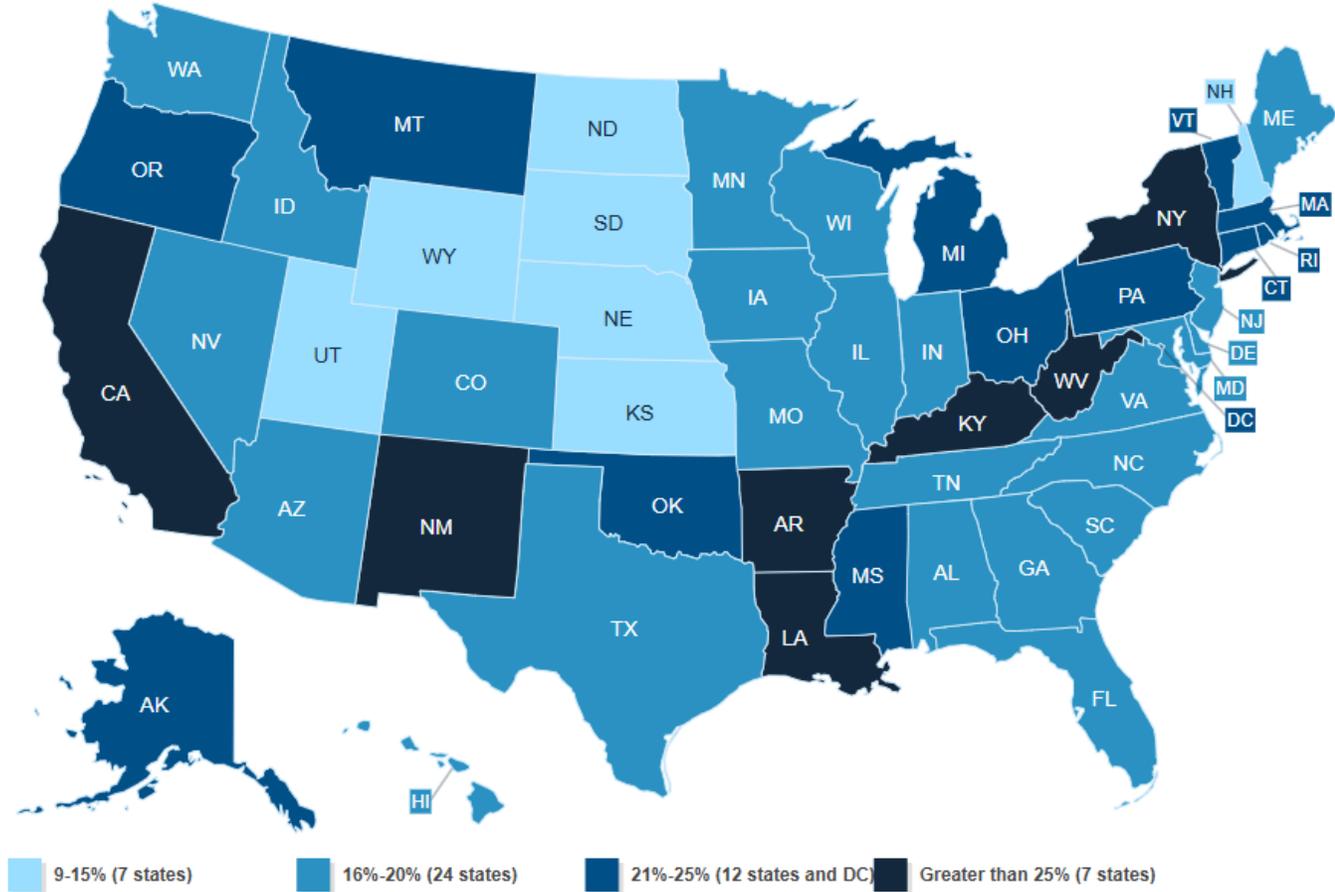
PERCENT OF PEOPLE COVERED BY MEDICAID/CHIP, 2022

Brief NH Medicaid Overview

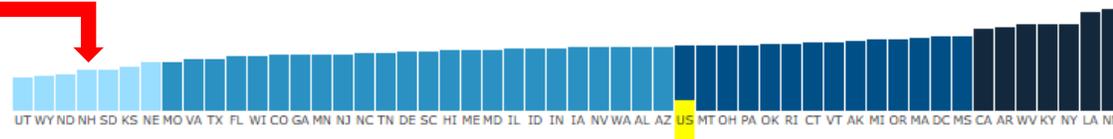
- New Hampshire has the 4th smallest Medicaid program in the nation.
- Approximately 1 in 7 New Hampshire residents are enrolled in Medicaid.
- Approximately 184,000 NH Medicaid enrollees.

Click below to download US fact sheet

United States

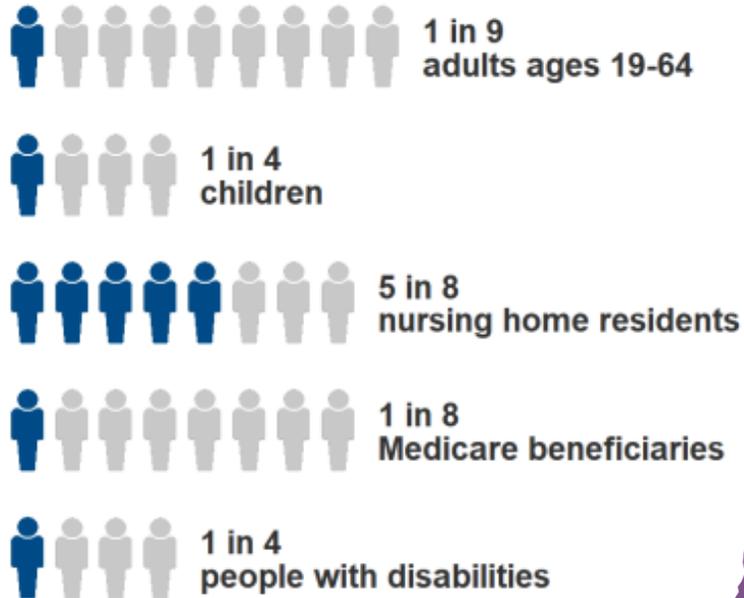


NH

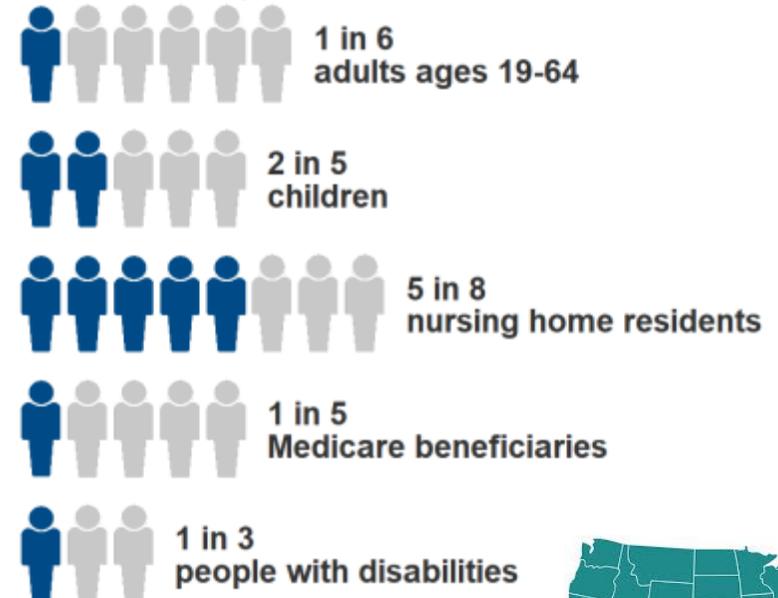


Fast Facts about NH Medicaid - Part 1

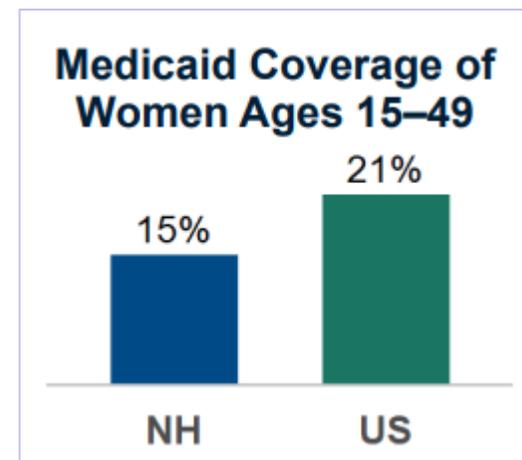
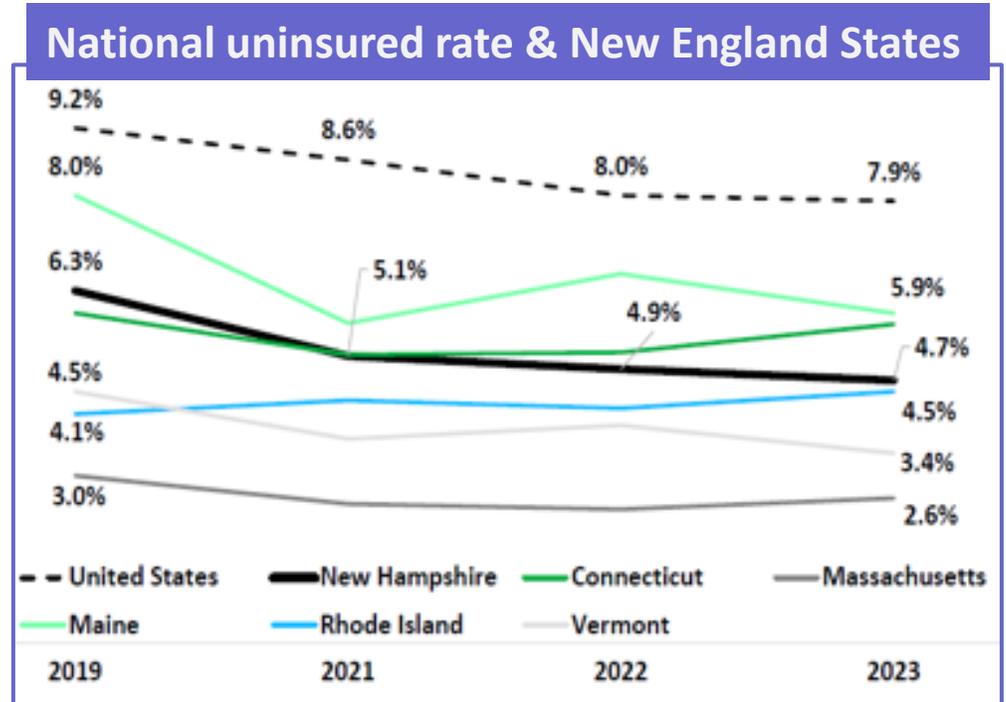
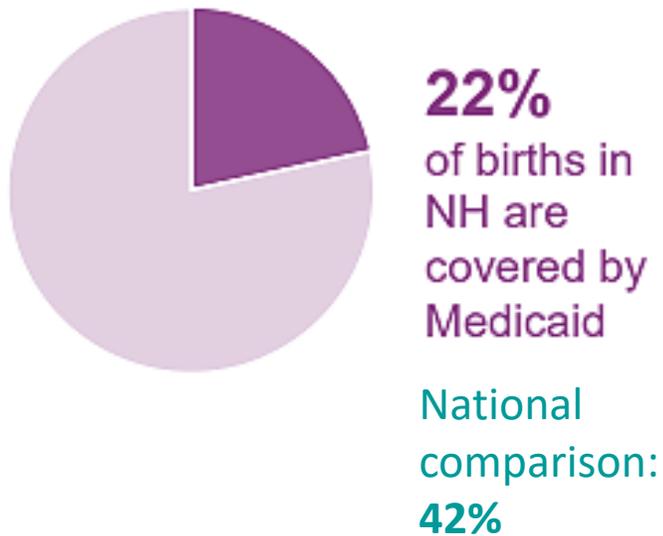
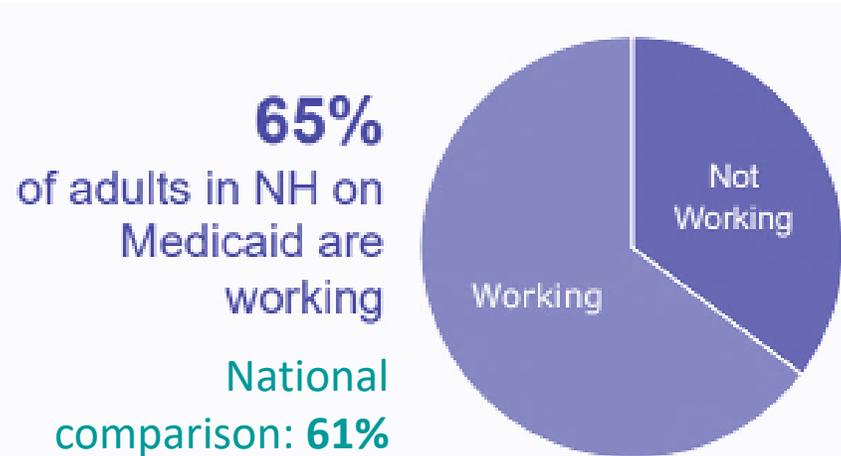
Medicaid covers approximately **184,000** Medicaid citizens or approximately 1 in 7 NH citizens



Medicaid covers more than **81,696,742** enrollees nationwide or 1 in 5 individuals



Fast Facts about NH Medicaid – Part 2



CAUTION

Medicaid

&

Medicare

are not the same!



Medicaid vs. Medicare

Medicaid	
Mandatory Eligibility Groups	Optional Eligibility Groups
<ul style="list-style-type: none"> Poverty-related infants, children, and pregnant women. Children with Title IV-E Adoption Assistance, foster care, or guardianship care. Elderly and disabled receiving SSI and aged, blind, and disabled Certain low-income Medicare enrollees (e.g. QMBs, SLMBs, and QI (aka SLMB135 in NH)) 	<ul style="list-style-type: none"> Poverty-related infants, children, pregnant women, elderly, and disabled above federal minimum standards Low-income adults (expansion population). Home and community based and waiver beneficiaries Individuals with specific diseases or services, such as breast and cervical cancer or family planning

Dual Eligible - Both
<ul style="list-style-type: none"> Medicare enrollee that meets Medicaid eligibility for blind or disabled Medicare pays for covered services first Certain low-income Medicare enrollees (e.g. QMB or SLMB) that meets Medicaid eligibility

Medicare
<ul style="list-style-type: none"> Federal Program All incomes 65 +, or any age with end state renal disease Under 65 with certain disabilities

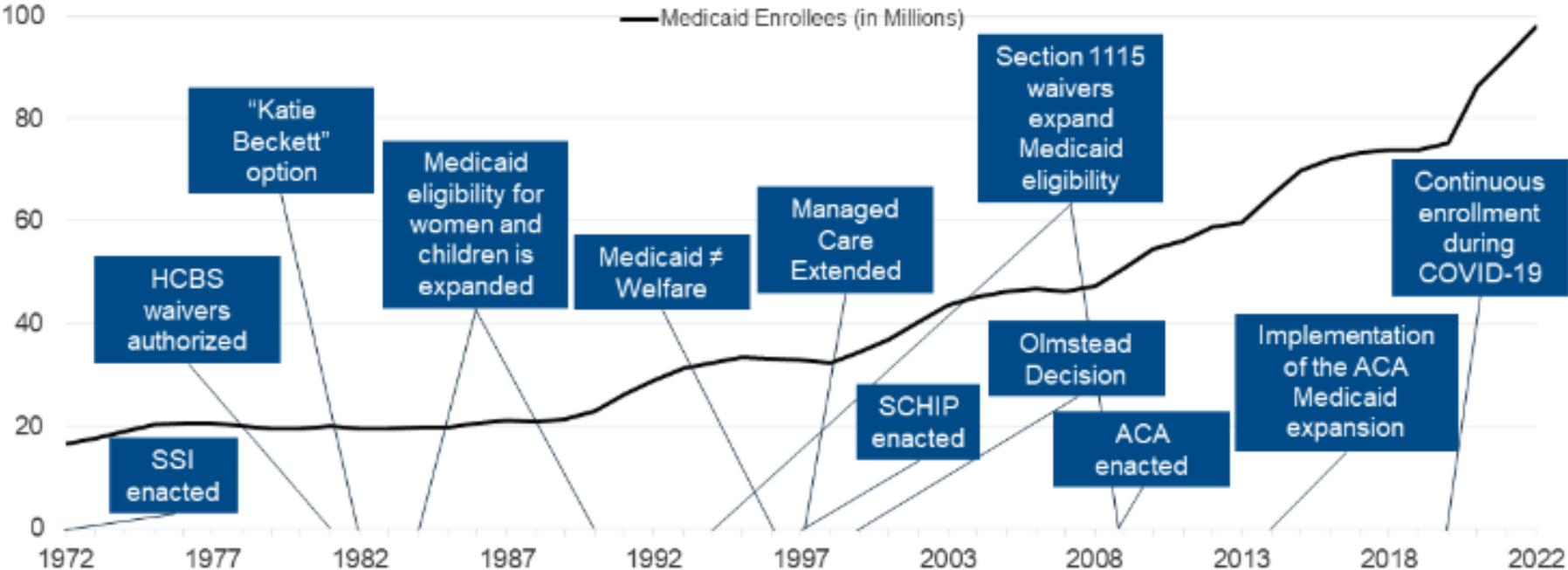


History of the federal Medicaid program

Figure 3

Medicaid's Evolution

Millions of Medicaid Enrollees



Source: Medicaid and CHIP Payment and Access Commission (MACPAC), MACStats: Medicaid and CHIP Data Book 2022

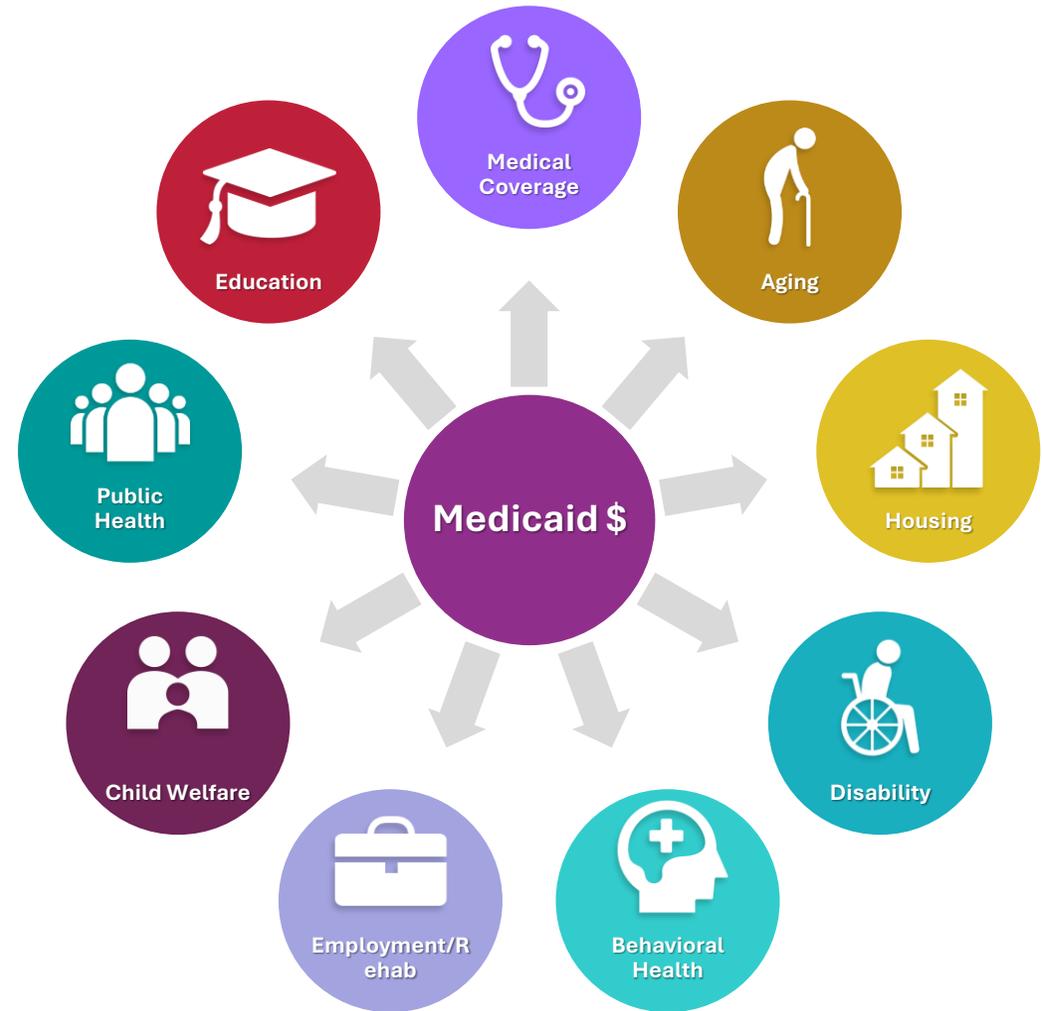
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NH Division of Medicaid (DMS) Mission

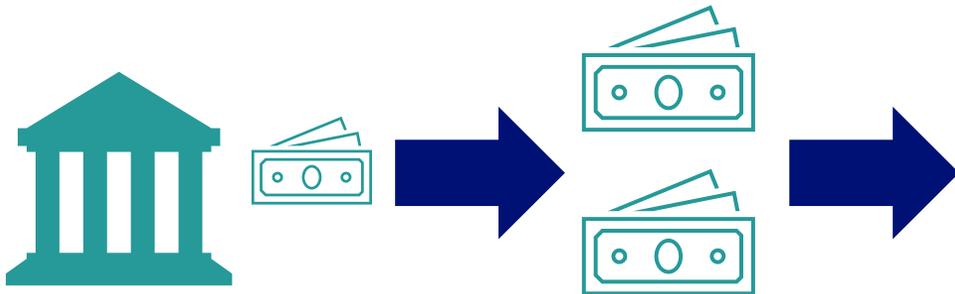
The mission of the Division of Medicaid Services (DMS) is to serve the healthcare needs of New Hampshire Medicaid beneficiaries through an effectively and efficiently run Medicaid Care Management and Fee For Service Program.

DMS operates this publicly funded health insurance program in a fiscally sound fashion while continuously striving to improve the quality of service and care for the approximately 1 in 7 New Hampshire citizens who have Medicaid.



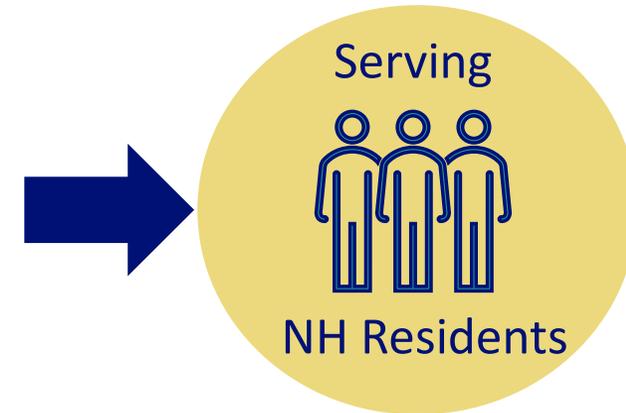
Leveraging State General Fund Investments is NH Medicaid's Key Role

Lead State partnership with Centers for Medicare and Medicaid Services to maximize State general fund investments



Lead Medicaid service programs to deliver health care services to NH Medicaid beneficiaries, including:

- The Medicaid Care Management and Fee-for-Service Program
- The Adult Dental Program
- Children's dental fee-for service
- **Medicaid-to-Schools**
- **Adult and Youth Community Re-Entry**
- **Maternal Opioid Misuse Model**
- Uncompensated Care
- In-Home Supports Waiver
- **SUD/SMI 1115 Waiver**
- **Mobile Crisis Services**



Part 2: NH Medicaid Eligibility & Enrollment



Medicaid Financial Eligibility Criteria

MANDATORY GROUPS	New Hampshire Eligibility Policy, if different	National Benchmark
Pregnant women (60 days postpartum) and children up to 6 years at 138% FPL	Pregnant women eligible for 12 months postpartum	48 other states have = adopted 12 months postpartum
	Pregnant women \leq 201% FPL	↓ NH ranks 34th highest income limit , within 10% national median
Children up to 19 years, \leq 138% FPL	Children up to 19 years, \leq 323% FPL	↑ NH has 5th highest income limit
Most individuals receiving SSI and related programs		
	Optional Group: Granite Advantage (Expansion population) \leq 138% FPL	= Equivalent income limit with 41 out of 42 states that elected expansion



Federal Poverty Levels

Household Size	100% FPL	138% FPL (Expansion Upper Income Limit)	201% FPL (Pregnant Women Upper Income Limit)	323% FPL (Kids Upper Income Limit)
1	\$15,650	\$21,597	\$31,456.5	\$50,549.5
2	\$21,150	\$29,187	\$42,511.5	\$68,314.5
3	\$26,650	\$36,777	\$53,566	\$86,079.5
4	\$32,150	\$44,367	\$64,621	\$103,844.5

Medicaid eligibility is determined at the individual level not the case level.

For example, a household income above 138% but below 323% would result in Medicaid coverage for the children but not the parents.



Upper Income Eligibility Limits for Children: National Perspective

State	Jan 2014	Jan 2015	Jan 2016	Jan 2017	Jan 2018	Jan 2019	Jan 2020	Jan 2021	Jan 2022	Jan 2023	May 2024
1. NY	405%	405%	405%	405%	405%	405%	405%	405%	405%	405%	405%
2. IA	380%	380%	380%	307%	380%	380%	380%	380%	380%	380%	380%
3. NJ	355%	355%	355%	355%	355%	355%	355%	355%	355%	355%	355%
4. DC	324%	324%	324%	324%	324%	324%	324%	324%	324%	324%	324%
5. CT	323%	323%	323%	323%	323%	323%	323%	323%	323%	323%	323%
5. NH	323%										
7. MD	322%	322%	322%	322%	322%	322%	322%	322%	322%	322%	322%
.....21 States.....											
26. TN, IN, KS, LA	255%	255%	255%	255%	255%	255%	255%	255%	255%	255%	255%
US	255%										



Upper Income Eligibility Limits for Pregnant Women: National Perspective

State	Jan 2014	Jan 2015	Jan 2016	Jan 2017	Jan 2018	Jan 2019	Jan 2020	Jan 2021	Jan 2022	Jan 2023	May 2024
1. IA	380%	380%	380%	307%	380%	380%	380%	380%	380%	380%	380%
2. DC	324%	324%	324%	324%	324%	324%	324%	324%	324%	324%	324%
3. CA	322%	322%	322%	322%	322%	322%	322%	322%	322%	322%	322%
4. AL	146%	146%	146%	146%	146%	146%	146%	146%	146%	146%	317%
5. WI	306%	306%	306%	306%	306%	306%	306%	306%	306%	306%	306%
6. MO	210%	201%	201%	305%	305%	305%	305%	305%	305%	305%	305%
6. WV	163%	163%	163%	163%	163%	163%	305%	305%	305%	305%	305%
8. MN	283%	283%	283%	283%	283%	283%	283%	283%	283%	283%	283%
9. CO	265%	265%	265%	265%	265%	265%	265%	265%	265%	265%	265%
10. MD	264%	264%	264%	264%	264%	264%	264%	264%	264%	264%	264%
US	255%										
28. MA, NJ, OH	205%	205%	205%	205%	205%	205%	205%	205%	205%	205%	205%
28. VA	148%	205%	205%	205%	205%	205%	205%	205%	205%	205%	205%
33. NE	202%	202%	202%	202%	202%	202%	202%	202%	202%	202%	202%
34. NH	201%										
34. NC	201%	201%	201%	201%	201%	201%	201%	201%	201%	201%	201%

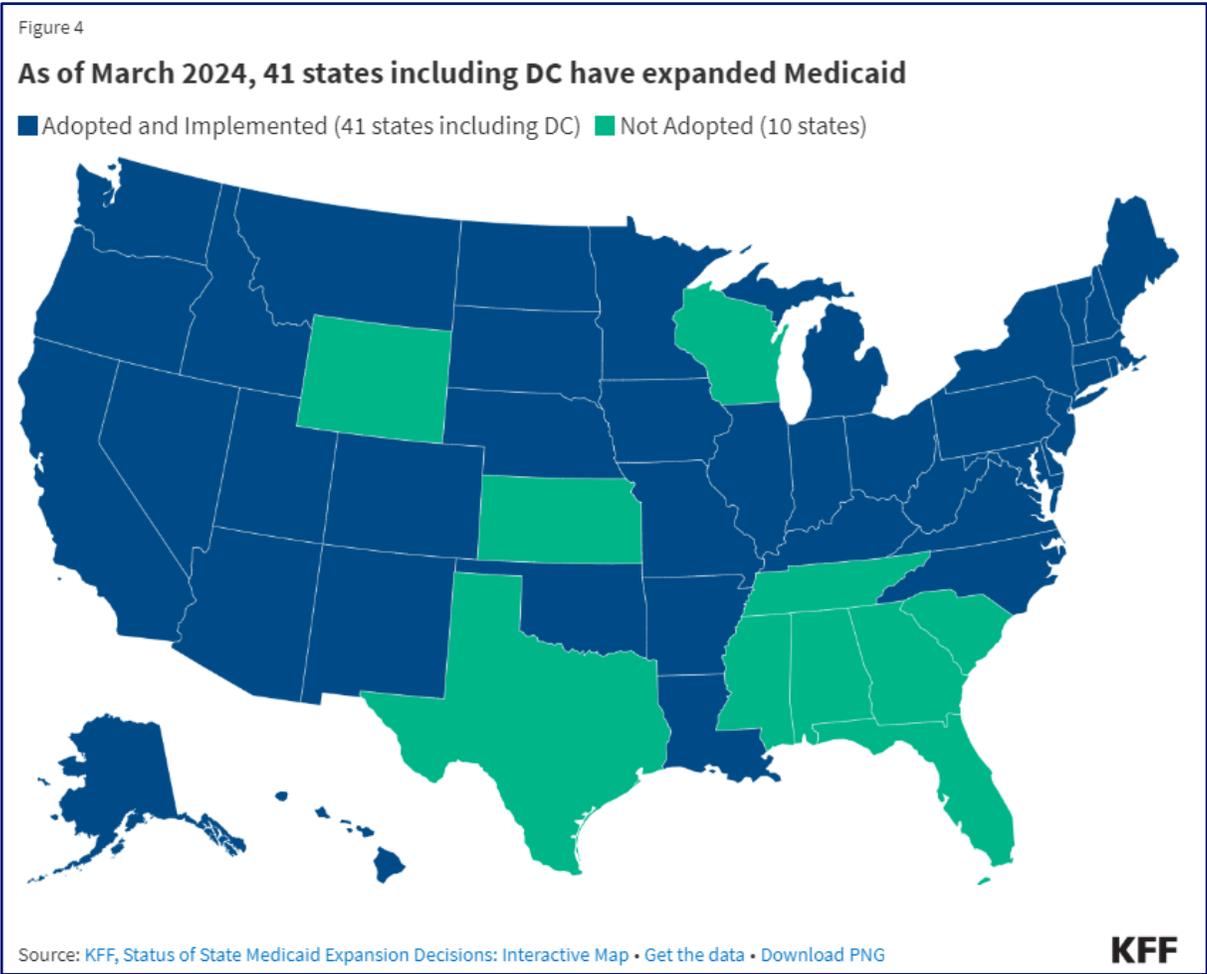
Trend in NH Medicaid Enrollment by Eligibility Group Since the Start of COVID-19 Pandemic

Period	Granite Advantage		Standard		Total	
3/16/2020 to 1/6/2025	59,524	+15.9% 8,159	125,340	-0.6% -715	184,864	+4.2% 7,444

Point in Time Trend

			% Δ	# Δ	Δ 3/28
Adult Groups	Adult Expansion - GAHCP	51,365	15.9%	8,159	-36,991
	Other Non-Disabled Adults	12,484	-4.5%	-561	-9,376
	Adults With Disabilities	16,393	-14.1%	-2,313	-4,020
	Elderly & Elderly With Disabilities	9,112	2.6%	235	-1,554
Child Groups	Low-Income Children - Non-CHIP	68,867	-2.9%	-1,987	-9,521
	Low-Income Children - CHIP	15,095	26.5%	4,007	-4,642
	Foster Care & Adoption Subsidy	2,827	3.6%	103	-324
	Children With Disabilities	1,277	-15.6%	-199	-65
Grand Total	177,420	4.2%	7,444	-66,493	

Medicaid Expansion

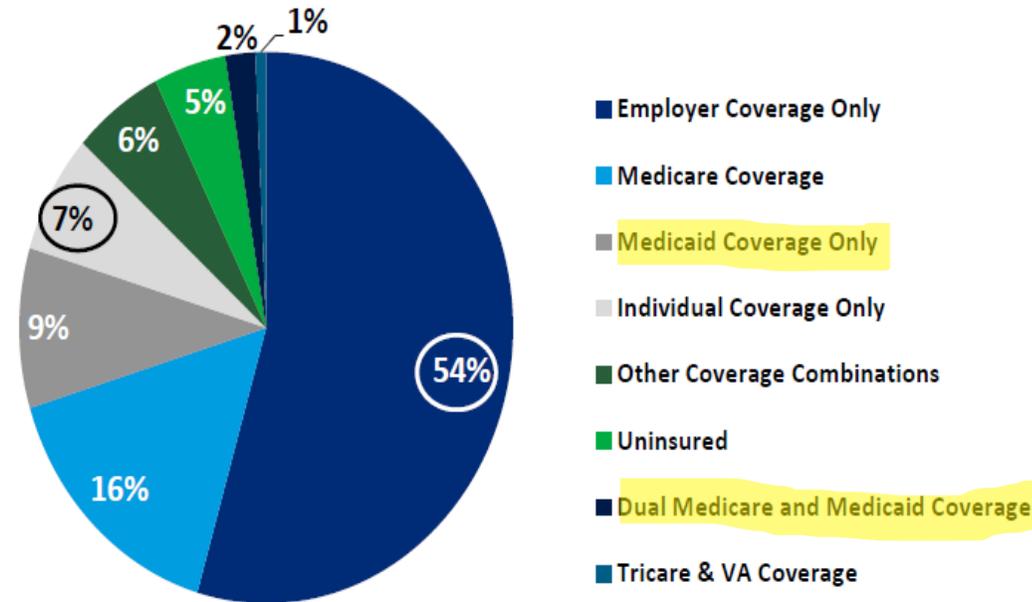


Granite Advantage Enrollment by Percent of Federal Poverty Level*

	0-50%	51-75%	76-99%	Above 100%	Grand Total
MGIA	31,160	4,591	6,185	10,213	52,149
MGIM (Medically Frail)	5086	455	601	954	7,096
Grand Total	36,246	5,046	6,786	11,167	59,245

- Medicaid expansion, nationwide, has a universal upper income limit of 138% of the Federal Poverty Limit.
- Since NH enacted Medicaid expansion in 2014, approximately 1 in 6 Granite State residents (252,106 residents) have benefited from Medicaid coverage.

Overview of New Hampshire Residents by Health Insurance Status in 2023



1,386,000 Total NH Residents

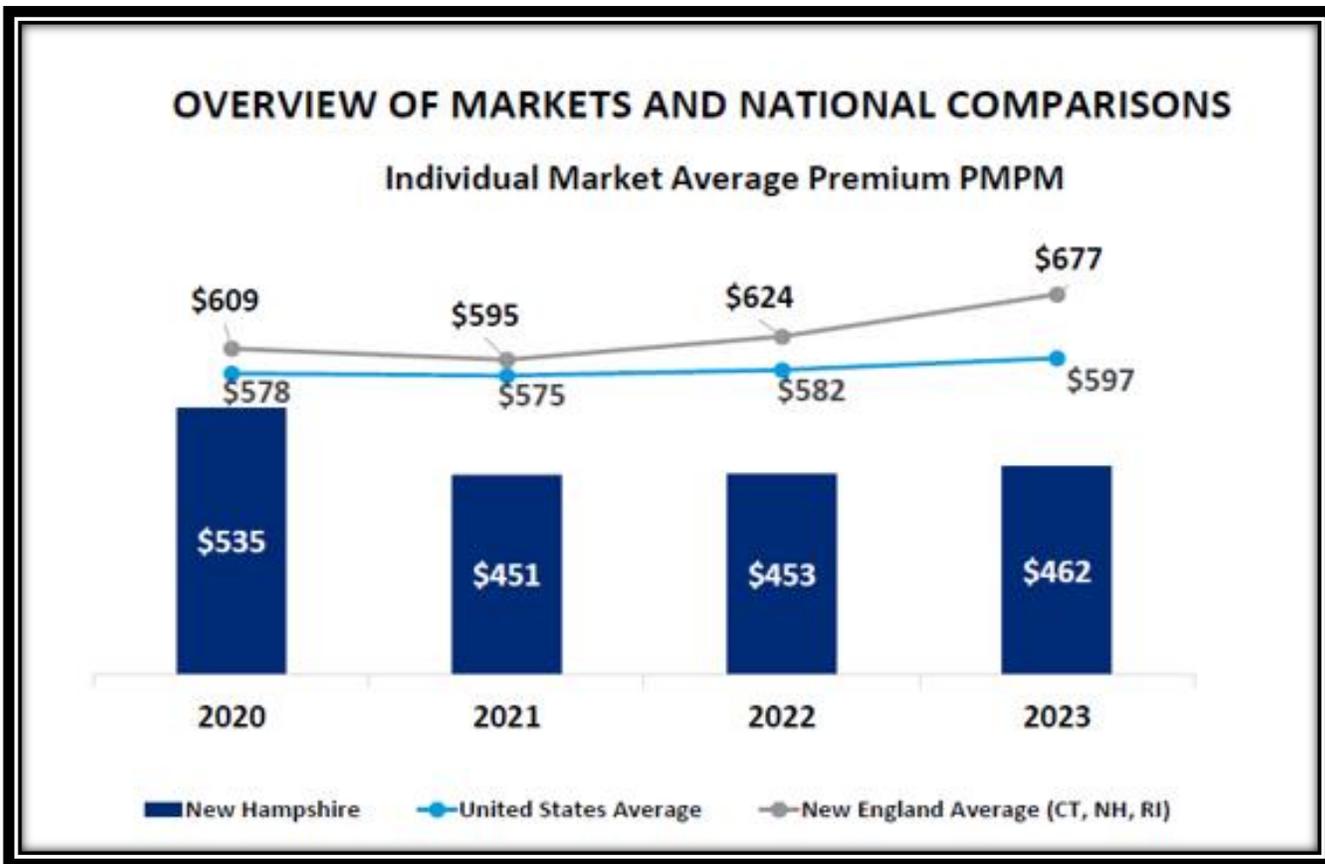
Approximately 62%, or 853,000, residents in New Hampshire received health insurance through the private insurance market, either through their employer or by purchasing their own coverage.

- This information is based on survey data and provides directional information on where NH residents receive health insurance coverage.
- The percentage of residents in New Hampshire who received coverage through the private insurance market has remained fairly steady, at approximately 61% to 62% for the past several years.
- Medicare coverage is the next largest coverage category after Employer coverage at 16% followed by Medicaid at 9%.
- Of the 1,386,000 NH residents approximately 66,000 did not have health insurance in 2023 which is approximately 4.7%.

Source: U.S. Census Bureau. 2023 American Community Survey 1-Year Estimate. The "Other Coverage Combinations" category includes those persons with two or more types of health insurance coverage that are not in the following six multi-coverage categories: With employer-based and direct-purchase coverage; With employer-based and Medicare coverage; With direct-purchase and Medicare coverage; With Medicare and Medicaid/means-tested public coverage; Other private only combinations; Other public only combinations.



Medicaid Expansion's Impact on the Individual Insurance Marketplace



- Average premiums in New Hampshire have **decreased** 15.6% in 2020 to 2021 due to the enactment of New Hampshire's reinsurance program through a Section 1332 Waiver.
- New Hampshire's premiums continue to remain significantly lower than the national average.
- A possible conclusion one could draw is that the combination of the 1332 Waiver by the New Hampshire Insurance Department and Medicaid Expansion have functioned to support the health of NH's insurance markets, including lower premium rates.

Part 3:
Medicaid Coverable
Services (Mandatory and
Optional)



Medicaid Covered Services

Mandatory	Optional
<ul style="list-style-type: none">✓ Inpatient hospitalization✓ Outpatient hospital✓ Physicians✓ Lab and x-ray✓ Home health✓ Nursing facility✓ Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for children	<ul style="list-style-type: none">✓ Prescription drugs✓ Eyeglasses and hearing aids✓ Organ transplants✓ Psychologists and other behavioral health✓ Dental✓ Physical/occupational/speech therapies✓ Rehabilitative✓ Intermediate care facilities for individuals with intellectual disabilities✓ Case management✓ Emergency hospital✓ Hospice✓ Transportation (Non-Emergency)✓ Prosthetic devices✓ Personal care

Highlighted optional benefits are commonly covered as Essential Health Benefits for plans on the Health Insurance Marketplace

Benefits can also be added through waivers.



Services to Children and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirement

- Introduced in 1967 to ensure that children and adolescents receive age-appropriate preventive, dental, mental health, and developmental, and specialty services.

Early

- Assessing and identifying problems early

Periodic

- Checking children's health at periodic, age-appropriate intervals

Screening

- Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems

Diagnostic

- Performing diagnostic tests to follow up when a risk is identified, and

Treatment

- Control, correct or reduce health problems found.

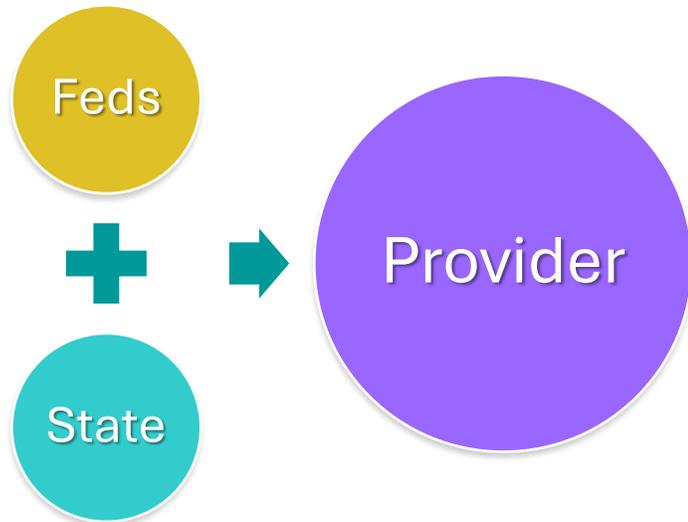


Part 4:

Key Financing Issues



Medicaid Financing in a nutshell

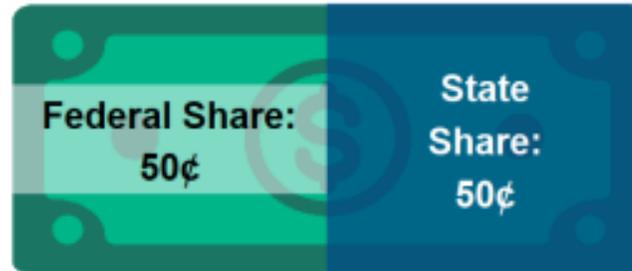


State-Federal Share

- Unlike much of public health financing, Medicaid agencies are **not** paid through grants
- Federal government pays a guaranteed percentage of all Medicaid costs (medical and administrative)
- Determined by federal medical assistance percentage (**FMAP**) resulting in federal financial participation (**FFP**)
- Higher FMAP in states with lower per capita incomes
- Different percentages for administration (50 percent) and IT (75 or 90 percent)

Federal Medical Assistance Percentage or FMAP

In NH, the federal government pays **50%** of the cost of traditional Medicaid.



The federal government pays **90%** of the cost of the Medicaid expansion.

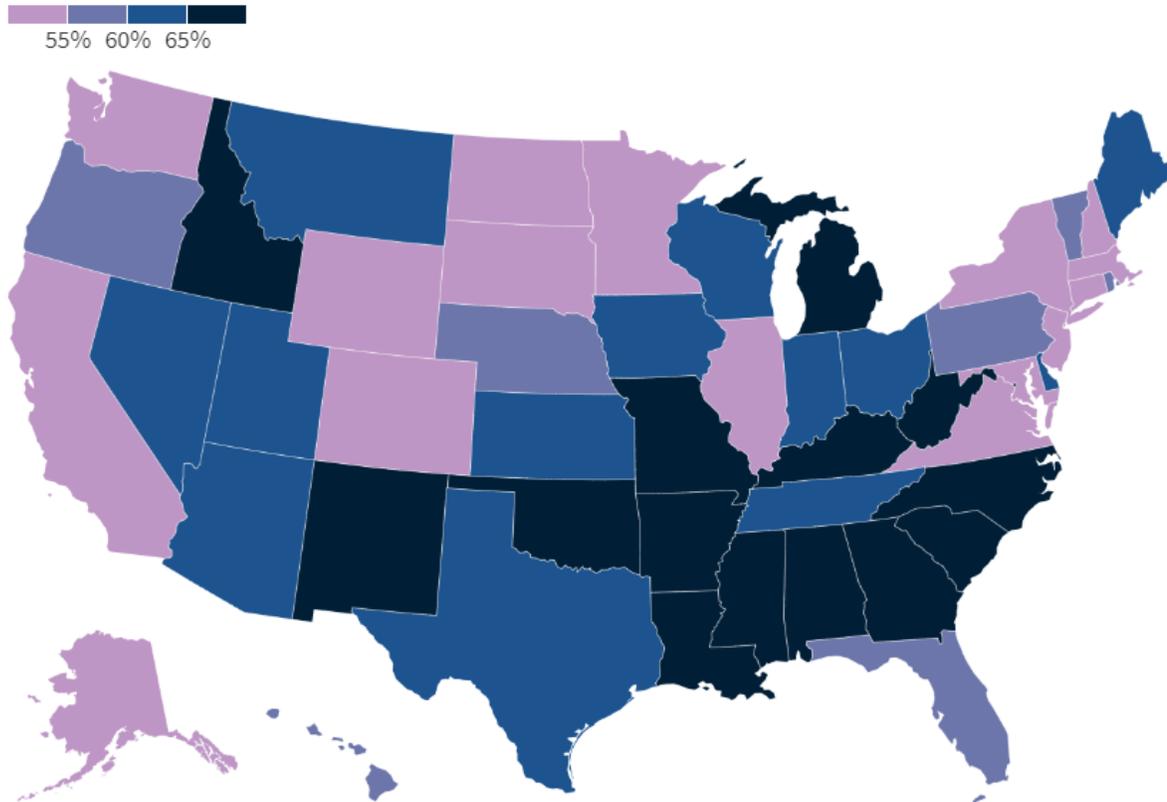


- **FMAP** is the share of state Medicaid costs paid by the federal government
- FMAP is calculated based on a 3-year average of state per capita personal income compared to national average
- No state can receive less than 50% or more than 83%
- States also receive “enhanced FMAPs” for expansion populations under the ACA and for the Children’s Health Insurance Program (CHIP)
- State share must be State public dollars or other allowable non-federal revenue.

Federal Matching Percentages Nationwide

Figure 5

The Federal Matching Rate Ranges from 50% to 77% Across States for FY 2025.



Note: FMAP = Federal Medical Assistance Percentage. These rates are in effect October 1, 2024 - September 30, 2025.

Source: [Federal Register, November 21, 2023 \(Vol 88, No. 223\), pp 81090-81093](#) • [Get the data](#) • [Download PNG](#)

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Comparison of FMAP- Selected States

New England States

- CT, NH, MA = 50%
- RI = 57.50% ↑
- VT = 59.01% ↑
- Maine = 61.29% ↓

Highest FMAP

- MI = 76.9%
- WV = 74.22% ↑
- AL = 72.63% ↓
- NM = 71.66% ↓

Lowest FMAP (50%)

- California
- Colorado
- Connecticut
- Maryland
- Massachusetts
- New Hampshire
- New Jersey
- New York
- Washington
- Wyoming

↑=increase from last year

↓=decrease from last year



Examples of Special/Enhanced Federal Matching Percentages

Service/Population	Special/Enhanced FMAP Percentage
Granite Advantage	90%
Breast and Cervical cancer treatment	65%
Children's Medicaid expansion	65%
Family planning	90%
DSH	50%
Rates/Directed Payments	Blended (50%-65%-90%) based on the individual's eligibility category

FMAPs and Leverage of the State Dollar: Examples

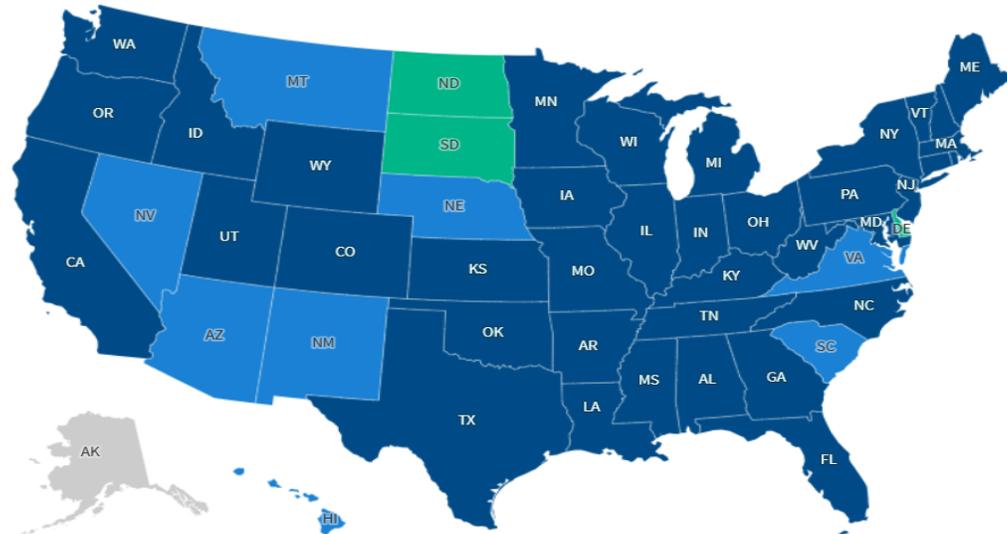
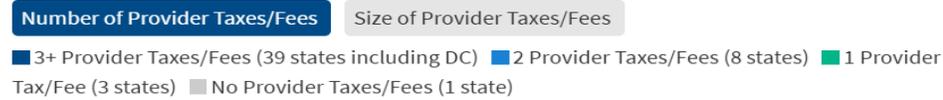
Service/Population	Gross Spend	FMAP	State Spend \$\$	Federal Match \$\$
Granite Advantage	\$1,000	90%	\$100	\$900
Standard Medicaid	\$1,000	50%	\$500	\$500
Expanded Children's	\$1,000	65%	\$350	\$650



Provider Taxes/Fees

- Nationally, provider taxes/fees fund more than 15% of the non-federal share of total Medicaid payments.
- As of July 1, 2024, 39 states had 3 or more provider taxes.
- New Hampshire's three taxes are the (1) Medicaid Enhancement Tax (5.4%); (2) Nursing Facility Quality Assessment (5.5%); and (3) Premium Tax (2%).

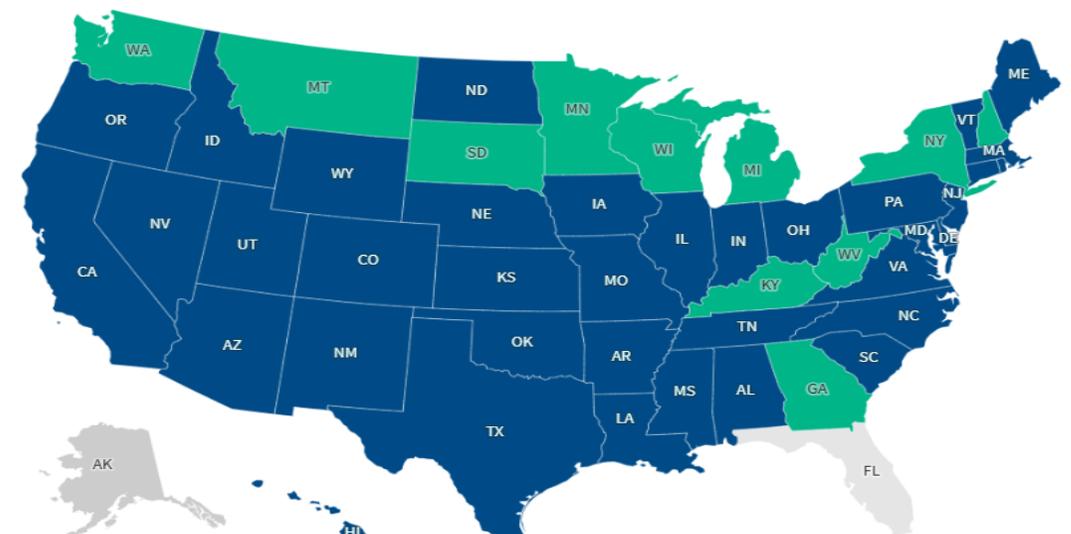
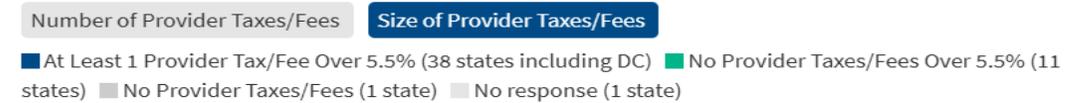
States with Provider Taxes or Fees in Place in FY 2024



Note: Includes Medicaid provider taxes as reported by states; refer to Table 4 for additional information about types of provider taxes in place. FL did not respond to the 2024 survey; publicly available data used to verify taxes in place.
 Source: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2024 • [Get the data](#) • [Download PNG](#)



Size of Taxes as Percentages in Place in FY 2024

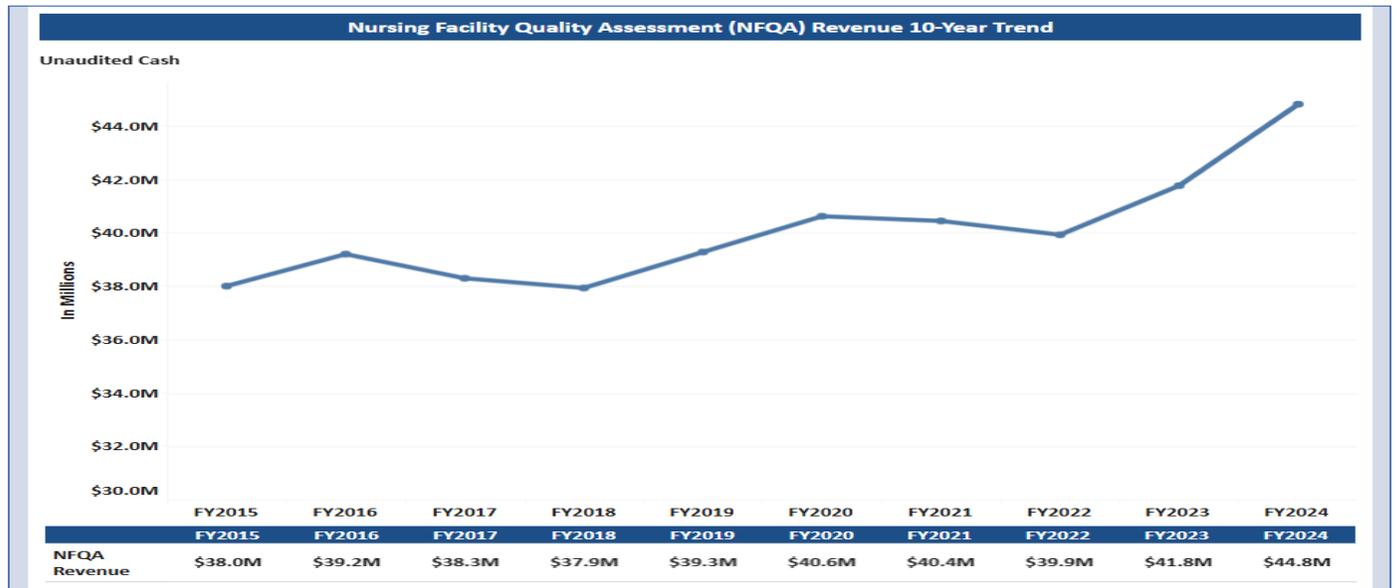
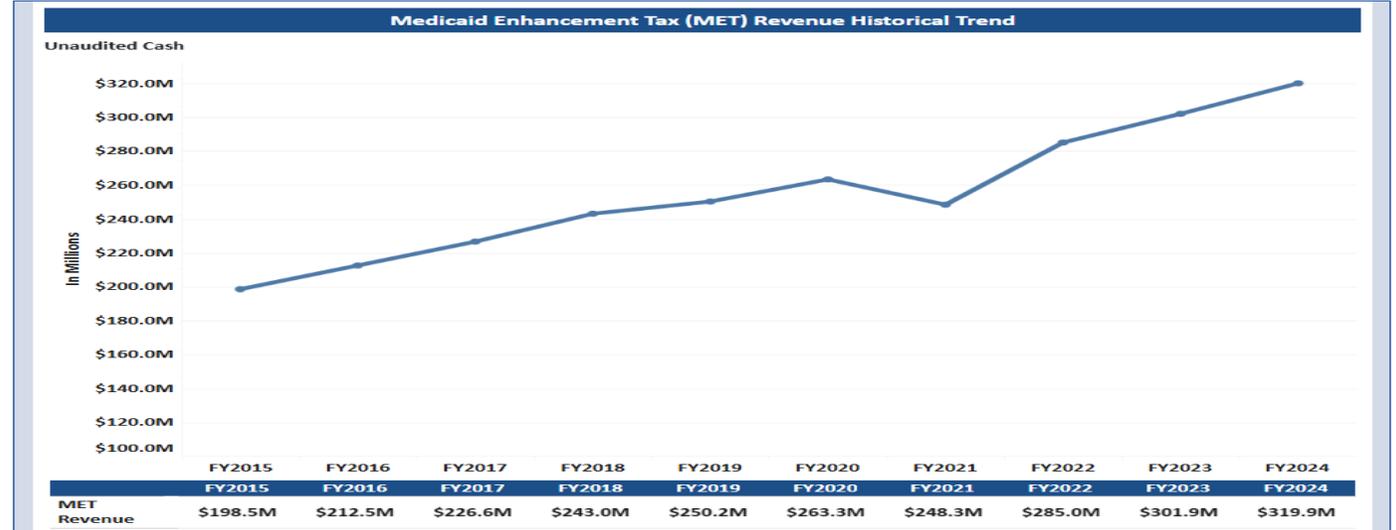


Note: Size of tax is reported as a percentage of net patient revenue (as of July 1, 2024). Includes Medicaid provider taxes as reported by states. FL did not respond to the 2024 survey; publicly available data used to verify taxes in place but not the size of the taxes.
 Source: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2024 • [Get the data](#) • [Download PNG](#)



New Hampshire Medicaid Provider Taxes

- Medicaid Enhancement Tax (the “MET”):**
 enacted in 1991. The tax is assessed on the net patient services revenue of every general acute care hospital in New Hampshire at a rate of 5.4% for the taxable period ending June 30, 2017, and forward. The taxable period is the 12-month period beginning July 1 and ending June 30.
- Nursing Facility Quality Assessment:**
 enacted in 2004. The tax is assessed on "net patient services revenue" at a rate of 5.5%. Nursing facilities pay the NFQA quarterly. The assessment period is the 3-month period beginning July 1, October 1, January 1, and April 1, of each year.



How does NH Medicaid use MET Dollars

- Medicaid uses MET revenue to reimburse hospitals and other Medicaid enrolled service providers (e.g. CMHCs, FQHCs, SUD providers, primary care, etc.) for the delivery of Medicaid coverable services to New Hampshire Medicaid beneficiaries.
- MET revenue is matched at the applicable FMAP and paid to hospitals and other Medicaid enrolled service providers through rates, directed payments, and disproportional share hospital (DSH) uncompensated care for Medicaid payments.
 - **Directed Payments:** A CMS approved state option to direct the MCO to pay a provider a specific rate.
 - **DSH Uncompensated Care Payments:** Hospital payments to subsidize uncompensated care costs related to services provided to Medicaid patients and the truly uninsured.

Illustrative Example of using MET to support rates or directed payments versus DSH uncompensated care payments

Type of Payment	MET Used	FMAP (Federal Funds)	Total Funds
\$10M Medicaid Uncompensated Care Payments (e.g. DSH)	\$5M	\$5M	\$10M
\$10M in Rates or Directed Payment	~\$4.6M	~\$5.4M	\$10M

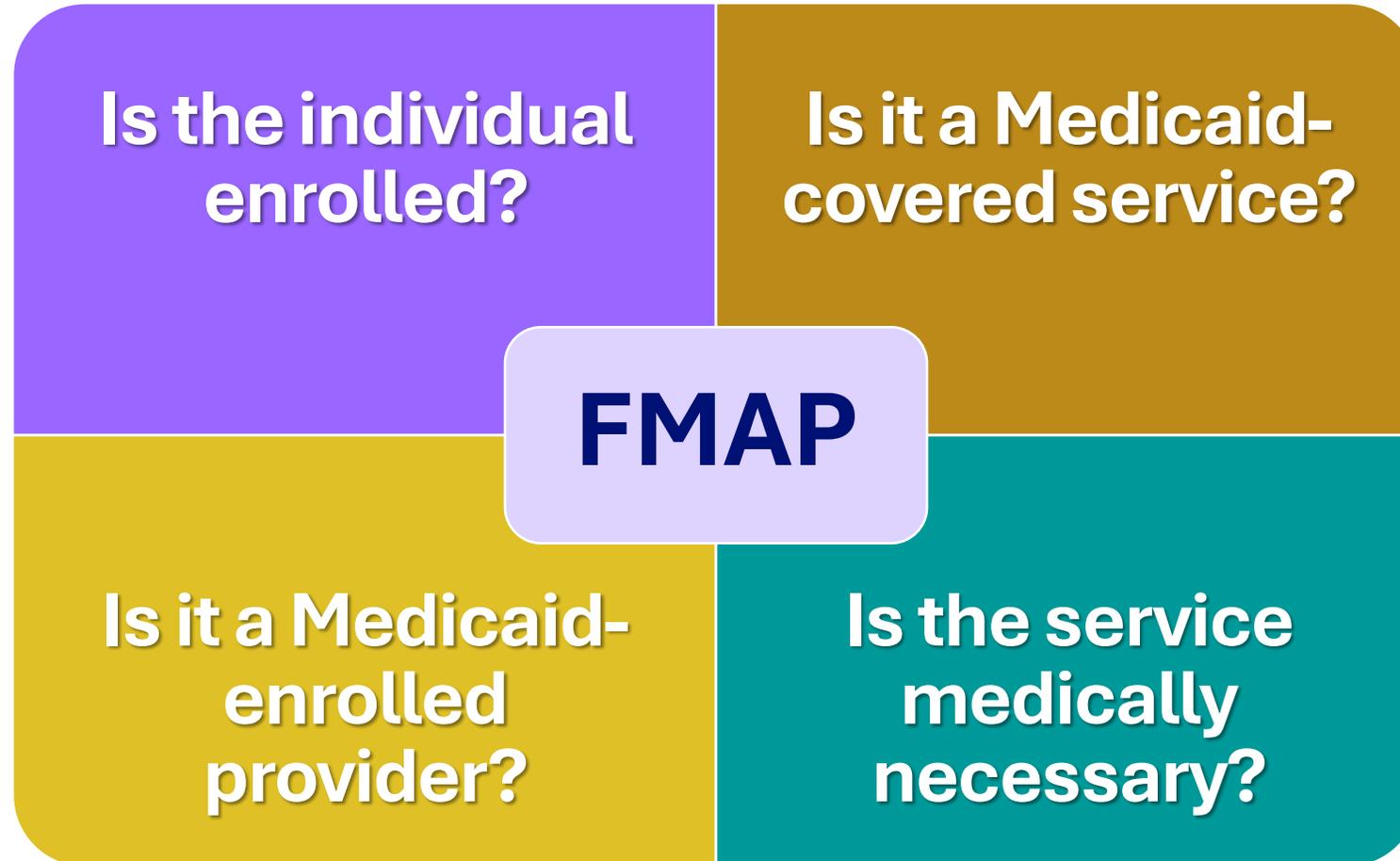


Part 5:

Medicaid Provider/Service Payment Fundamentals

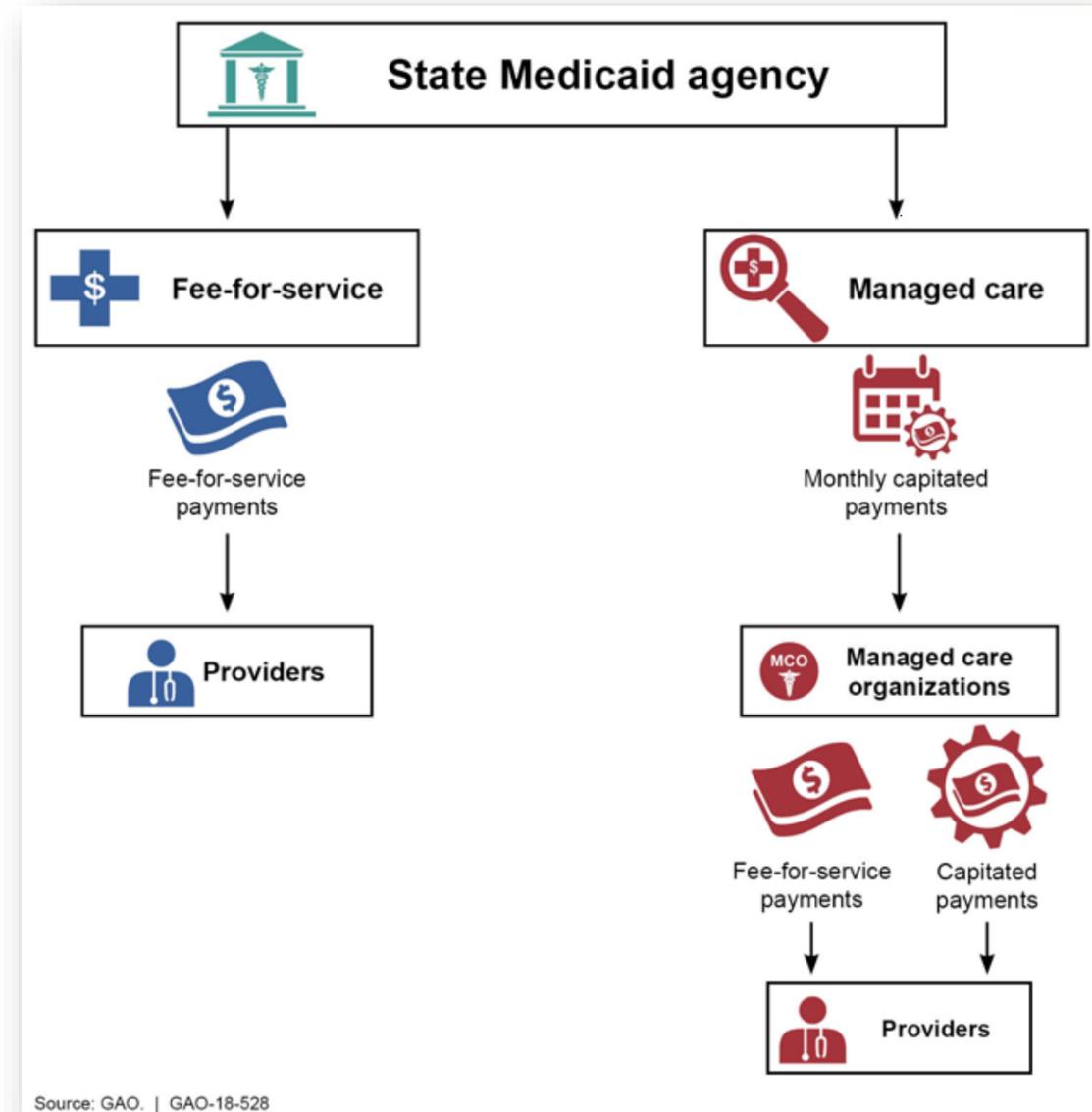


When will Medicaid pay?



Where do the Funds Go?

States have an array of options for the delivery model



MCM 3.0 Featured Programmatic Changes (September 1, 2024 – August 30, 2029)



Primary Care and Preventive Services Model of Care. MCM programmatic changes to build authentic patient/primary care provider relationships, and incentivize provider-delivered care coordination, health risk assessments and comprehensive medication reviews.



High-Cost Pharmacy Risk Pool for High-Cost Therapies. Shifts risk from the State to the MCOs by including high-cost drugs and therapies in MCM. MCOs share in the utilization management and risk of new high-cost drugs and gene therapies.



Focused MCO-delivered Care Management for priority populations. Focuses enhanced MCO care management on previously incarcerated members, DCYF-involved children, infants with low-birthweight and/or NAS, and members with a behavioral health inpatient facility admission within past 12 months. Allows State to identify additional priority populations.



Restructure of CMHC Capitation Model. Further aligns funding with state behavioral health investments and program goals.

Certified Community Behavioral Health Centers. Integrates behavioral health and SUD in one location. Two CMHCs, Manchester and Nashua, implemented on 1/1/25 as a CCBHC.



Strengthened Reliability, Quality, Safety, and Access in the performance of the NEMT program. Elevated standards and remedies applied to MCOs' performance of oversight of their NEMT brokers and transportation providers.



Integrated Pharmacy Benefit Management

Streamlines existing systems and improves cost-savings

Integrated Medication Management

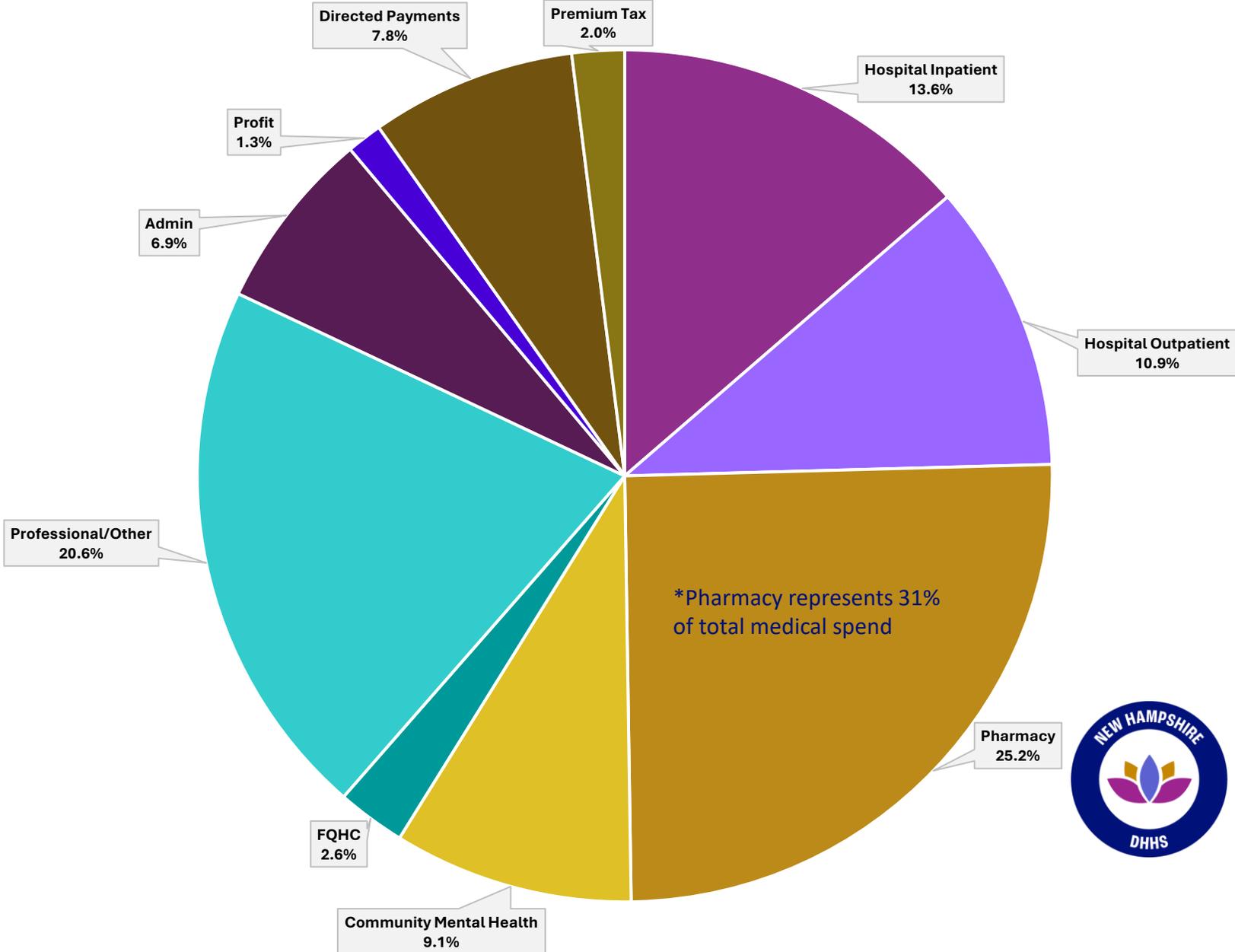
- Increase provider capabilities for reimbursable Rx review activities
- Contract criteria for polypharmacy review and DHHS authority on PA review criteria
- Member incentives for engagement in medication review
- Extend Rx efficiency analyses

High-Cost Pharmacy Risk Pool

- Strategy for financial management of largest and least predictable cost area for MCM program
- Allocates funding to MCOs based on outlier cost pharmacy claims
- Expected effect: Sharing Risk with MCOs and promoting MCO engagement in the course of care and treatment



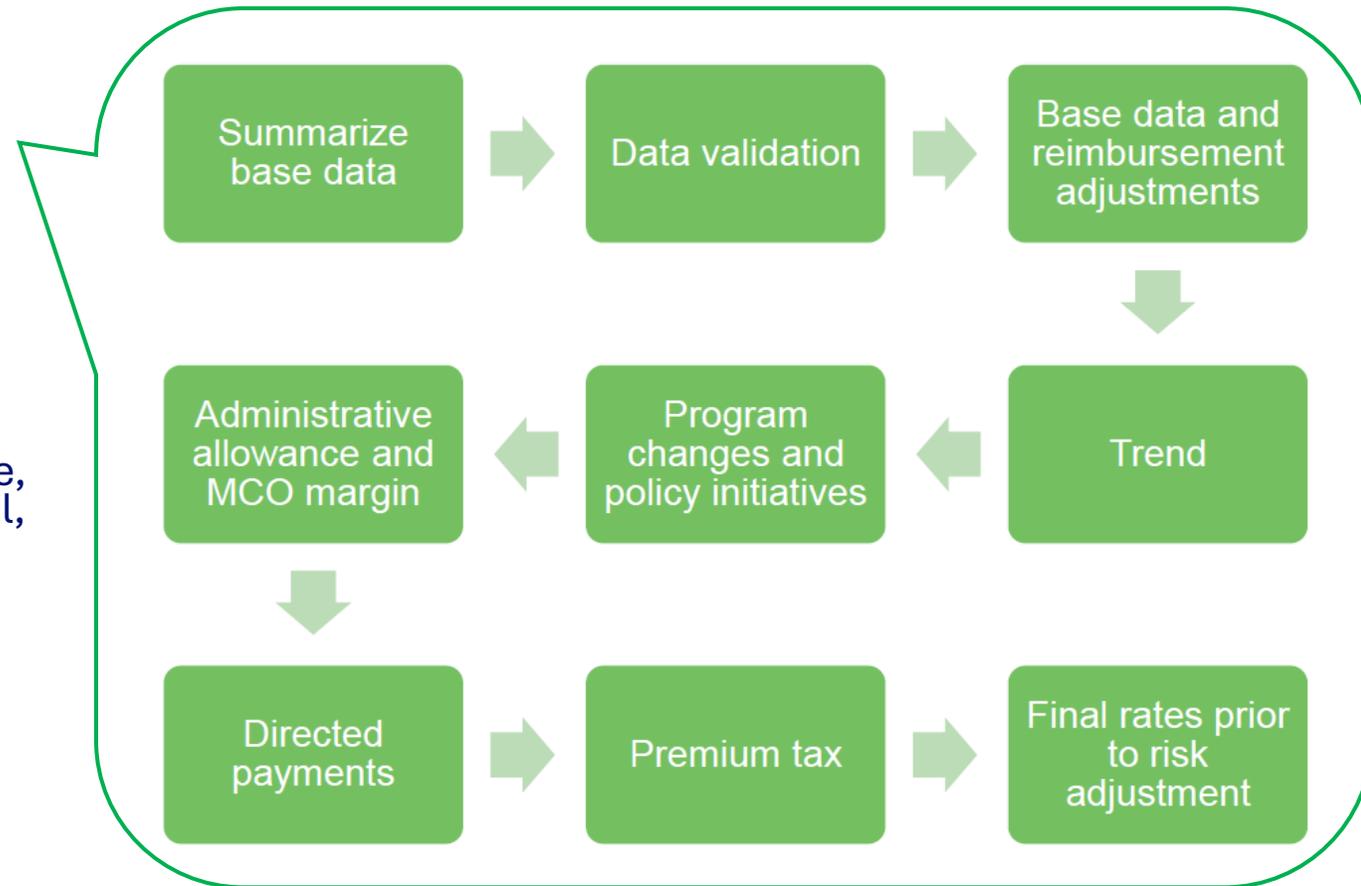
Amendment #2 MCO Capitation Rate Funding



Department of
**HEALTH &
HUMAN SERVICES**

Steps to Arrive at a CMS Certified MCO Capitation Rate to Claim Federal Match

1. MCO capitation rates are developed by the State's actuary in accordance with CMS standards: [2024-2025 Medicaid Managed Care Rate Development Guide](#)
2. Capitations rates are presented to, and negotiated with, the MCOs.
3. MCO contracts, inclusive of the MCO capitation rate, are proposed and voted on by Governor and Council, which is subject a price limitation within the budget appropriation.
4. Latest MCO Contract Amendment: **79.3% Federal Funds***, 12.4% Other Funds, 8.3% General Funds” available at: media.sos.nh.gov/govcouncil/2024/1218/13A GC Agenda 121824.pdf



*The MCO Contracts include both standard Medicaid and Granite Advantage (which is funded outside of the budget).



Two Pathways for Federal Approval to Cover Medicaid Services

State Plan

Flexibility within
existing federal
regulations

Waivers

Flexibility
beyond existing
federal
regulations



Vehicles for changes to State Medicaid Programs

Authority	Description
State Plan Amendment	<ul style="list-style-type: none"> ■ Permanent state Medicaid plan change to eligibility, benefits, and rates ■ Some special types: <ul style="list-style-type: none"> ■ <i>1915(i) State Plan Home- and Community-based Services</i>: Targets services to certain populations meeting need and risk criteria (e.g., housing services and supports for people with behavioral health conditions) ■ <i>1915(k) Community First Choice State Plan Option</i>. Provides home and community-based attendant services and supports to eligible Medicaid enrollees.
Section 1915(b)	<ul style="list-style-type: none"> ■ State can: request mandatory managed care enrollment for all populations, implement a primary care case-management system or a specialty physician system, and use cost savings to provide additional services.
Section 1915(c)	<ul style="list-style-type: none"> ■ Provides home- and community-based services as an alternative to institutional settings
Section 1115	<ul style="list-style-type: none"> ■ Broad waiver authority to test innovations



Waiver and SPA Criteria Differ

Considerations	SPA	1915(b) waiver	1915(c) waiver	1115 Waiver
Purpose	Varies	Mandatory managed care	Home & Community-Based Services	Demonstration to test innovative policy
Approval period	Permanent	2 years (5 for duals), renewed for 2	3 years, renewed for 5	5 years, can be extended for 3-5 years
Proof of public notice/input required with submission?	Yes – for certain SPAs (rate changes)	Encouraged -- Only tribal consultation explicitly required	Yes	Yes – detailed requirements in federal rule
Limitations on cost?	No	Must be “cost-effective”	Must be “cost neutral” (aggregate per capita)	Must be “budget neutral”
Freedom of choice, statewideness, comparability applies?	Typically applies, except for special types	Can be waived	Only state wideness & comparability can be waived	Can be waived
Required evaluation?	No	Sometimes – mostly monitoring & reporting	No – mostly monitoring & reporting	Yes



1915 Waivers (State Options)

	Name	Began	Start	End
1915 (b)	Mandatory Managed Care for State Plan Services for Currently Voluntary Populations (NH-01)	2015	10/01/2024	09/30/2026
1915 (b)	Medicaid Care Management Dental Services	2023	04/01/2023	03/31/2025
1915 (c)	In Home Supports for Children with Developmental Disabilities	2003	01/01/2021	12/31/2025
1915 (c)	Acquired Brain Disorder Waiver (4177.R06.00)	1993	11/01/2021	10/31/2026
1915 (c)	Developmental Disabilities Waiver	1987	09/01/2021	08/31/2026
1915 (c)	Choices for Independence Waiver	1984	07/01/2022	06/30/2027



1915 (State Plan Options)

	Name	Began	Start	End
1915 (i)	Supportive Housing	2022	7/1/2022	6/30/27
1915 (j)	Personal Care Services	2023	5/12/2023	
1915 (i)	Fast Forward (SED Children)	2016	7/1/2023	6/30/28

1115 Waivers

	Name	Began	Start	End
1115	Substance Use Disorder Serious Mental Illness and Serious Emotional Disturbance Treatment Recovery and Access	2018	7/16/2024	6/30/2029
1115	New Hampshire COVID-19 Public Health Emergency (PHE) Demonstration	2020	3/01/2020	5/11/2023
1135	Disaster Waiver	2020	3/18/20	5/11/23



State Plan Options

State Plan

Waivers

1915 (i) Supportive Housing Bureau of Homeless Services, Bureau of Mental Health Services, Division of Medicaid, July 1, 2022-June 30, 2027

1915(j) Personal Care Services - approved 5/12/2023

Developmental Disabilities (DD) 1915(c) Waiver Dates 9/1/2021-8/31/2026

In Home Supports (IHS) for Children with DD 1915(c) Waiver Dates 1/1/2021-12/31/2025

1915(i) Fast Forward (SED Children) 7/1/2023-6/30/2028 Bureau for Children's Behavioral Health

Acquired Brain Disorder (ABD) 1915(c) Waiver Dates 11/1/2021-10/31/2026 Bureau of Developmental Services

1915 (b) Dental - April 1, 2023-March 31, 2025 Division of Medicaid

Choices for Independence (CFI) 1915(c) Waiver Dates 7/1/2022-6/30/2027 Bureau of Adult & Aging Services

Managed Care 1915(b) Waiver Dates 10/1/2024-9/30/2026 Division of Medicaid

1115 Waiver SUD-SMI IMD, Nursing Facility Dentures, Community Reentry. Waiver Dates: 7/01/2024-6/30/2029 Division of Medicaid

1135 Disaster Waiver Dates 3/18/2020-5/11/2023 Division of Medicaid

Granite Advantage 1115 Waiver Dates 1/1/2019-12/31/2023 Suspended by court order (work requirement) Division of Medicaid

Epilogue:

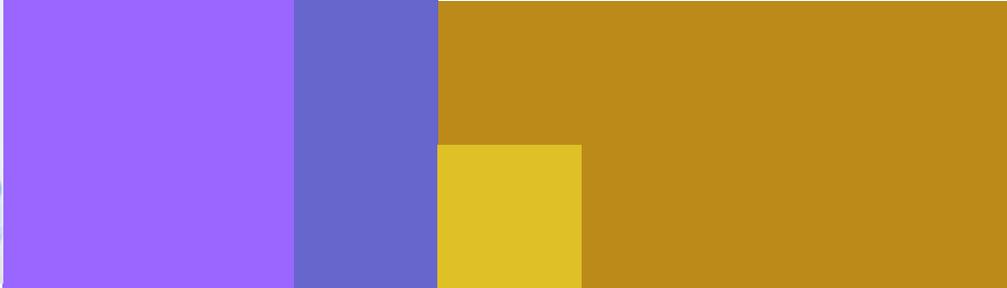
Risk of Federal Changes to the Federal Financing of Medicaid



Currently Circulating Federal Risks to Medicaid Federal Funding (Congressional Budget Reconciliation)

	Proposal	Impact
FMAP Reduction	<p>Eliminating the enhanced FMAP for expansion: Currently 90% for Granite Advantage</p> <p>Lowering the minimum FMAP: NH currently receives the minimum of 50%</p> <p>Changing the formula used to calculate Medicaid FMAP: Insufficient details to determine impact to NH as a minimum FMAP state.</p>	Reduction in federal funding through a reduced match rate, shifting cost to state without reducing overall cost
Capping Federal Contribution	<p>Converting Medicaid to a per capita cap: states receive only a fixed federal contribution per beneficiary</p>	Funding structure for Medicaid changes entirely; all costs above a set capitation are borne by state
State Revenue Reduction	<p>Restricting use of provider taxes to finance state Medicaid costs: all states but Alaska rely on these taxes to finance Medicaid</p>	Significant reduction in state revenue available for financing Medicaid without reduction in overall program cost





Thank you.

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