



**School of Law / Institute for
Health Policy & Practice**

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Work/Community Engagement Requirement Stakeholder Roundtable

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Background Questions and Answers

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Contents

Key Documents	4
Background and NHHPP Income Data	4
What is NH’S Medicaid Expansion Work/ Community Engagement History Timeline?	5
Which States Have Adopted a “Work/Community Engagement Requirement” for Medicaid?	8
What is the Relationship Between the Work/Community Engagement Requirements in the CMS Approval of May 2018 and the Requirements in SB 313?	9
How Soon Can the Granite Advantage Work/Community Engagement Requirement Go Into Effect? ...	9
What Administrative Approvals Must DHHS Secure Prior To Implementation of the Granite Advantage Work/Community Engagement Requirement?	9
What Other Waivers or Coverage Requirements is DHHS Seeking as Part of the Granite Advantage Program Through the Granite Advantage 1115(a) Waiver Extension Application?	10
How Much Time is a Granite Advantage Beneficiary Given to Meet the Work/Community Engagement Qualifying Activity or Exemption?	11
What is the Work/Community Engagement Requirement for Granite Advantage Enrollees? What are the “Qualifying Activities”?	11
How Many Hours Must a Non-Exempt Granite Advantage Beneficiary Engage in Qualifying Activities?	13
Who is Exempt From the Work/Community Engagement Requirement and When and How Do They Demonstrate Such an Exemption?	13
Are the STC Exempt Populations the Same as Those Listed in SB 313?	15
What Happens if a Granite Advantage Beneficiary is Not in Compliance with the Work/Community Engagement Requirement?	15
How Does a Beneficiary “Cure” Work/Community Engagement Non-Compliance?	15
When Does “Good Cause” Excuse a Granite Advantage Beneficiary’s Failure to Meet the Work/Community Engagement Requirement Hours?.....	15
Are the STC “Good Cause” Excuses the Same as Those Listed in SB 313?	16
What are the Assurances the State Must Make to CMS Prior to Implementation of the Work/Community Engagement Requirement?	17
Will DHHS Draft Rules Regarding the Work/Community Engagement Requirement?	19
What will the Rules Adopted by the Commissioner Pursuant to SB 313 Address?.....	20
What Type of Resources Will Be Available to Support Beneficiaries Around Enrollee Status, Exemptions and Qualifying Activities?.....	20
What Type of Work Support Services Will Be Available to Support Enrollees with Qualifying Activities?	21



What Will The Benefits Look Like for Individuals Transitioning From the NHHPP PAP to Managed Care through the Granite Advantage Program? 21

Is Someone Certified as Medically Frail under NHHPP Required to Participate in the Work/Community Engagement Requirement Under the Granite Advantage Program? 22



Key Documents

- SB 313 (2018)
 - Bill Text:
http://www.gencourt.state.nh.us/bill_status/billText.aspx?sy=2018&txtFormat=html&v=HA2&id=1972
 - Enrolled Bill Amendment:
http://www.gencourt.state.nh.us/bill_status/billtext.aspx?sy=2018&txtFormat=amend&id=2018-2086EBA
- August 30, 2017, Draft Section 1115(a) Waiver Amendment
 - <https://www.dhhs.nh.gov/pap-1115-waiver/documents/hb517-nhhpp-work-reqs-2017.pdf>
- May 7, 2018 CMS Approval Letter and Special Terms and Conditions granting NHHPP PAP Section 1115 demonstration waiver amendment to include a work/community engagement requirement.
(<https://www.dhhs.nh.gov/pap-1115-waiver/index.htm>)
- May 8, 2018: DHHS' Granite Advantage Section 1115(a) Waiver Extension Application seeking to amend and extend the NHHPP PAP demonstration waiver by creating the new Granite Advantage Program, discontinuing the NHHPP PAP, and applying work/community engagement requirements to the Medicaid expansion population consistent with any authority granted by CMS.
(<https://www.dhhs.nh.gov/ombp/medicaid/documents/ga-waiver-app-05082018.pdf>)

Background and NHHPP Income Data

The NHHPP is authorized pursuant to a CMS approved Section 1115(a) demonstration waiver. As of April 2018 approximately 52,910 beneficiaries were enrolled in the NHHPP. Of those, 41,354 were enrolled in a mandatory individual qualified health plan (QHP) Premium Assistance Program ("PAP")(effective since January 1, 2016) receiving coverage through commercial insurance carriers offering plans in New Hampshire's federally facilitated Marketplace. Approximately 7,863 NHHPP enrollees are considered "medically frail" or are for other reasons served by one of NH's two Medicaid Managed Care Organizations (MCOs).

Because eligibility for Granite Advantage benefits is based on income (138% FPL), the income spread of the NHHPP is referenced. Fifty three percent (53%) of PAP enrollees have incomes of less than 50% of the Federal Poverty Level (FPL). Twenty four percent (24%) have incomes between 50-100% of FPL and twenty three percent (23%) have incomes between 100-138% of FPL. Enrollees with income between 100-138% of FPL are subject to copayments with a maximum quarterly out-of-pocket responsibility of \$147 per enrollee or no more than 5% of household income. Distribution of enrollees by income level has remained consistent throughout the first quarter. See 1115 Waiver NHHPP Quarterly Report, 1/1/17-3/31/17. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-qtrly-rpt-jan-mar-2017.pdf>

At the end of the first quarter of Demonstration Year 2, approximately 14% of NHHPP enrollees identified as medically frail. Of the 14% who identified as medically frail, the majority, approximately 65%, have incomes of less than 50% of FPL as of March 2017. *Id.*



What is NH'S Medicaid Expansion Work/ Community Engagement History Timeline?

Key Dates and Documents

- **March 27, 2014:** SB 413 expands Medicaid through the NHHPP until January 1, 2017, and relies on 100% federal funding. The legislation requires a PAP waiver be approved by March 31, 2015. (Version adopted by both parties as of 3.25.14: https://gencourt.state.nh.us/legislation/2014/SB0413_HOTP.html; enrolled bill amendment on 3.26.14: <http://www.gencourt.state.nh.us/legislation/amendments/2014-1167EBA.html>)
- **July 1, 2014:** NH's Medicaid expansion goes into effect. (<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/new-hampshire-mcp.pdf>)
- **August 15, 2014:** Coverage becomes effective for the newly eligible adult group ages 19-64 (new adult group), with incomes between 0-138% of the Federal Poverty Limit, enrolling in the managed care "bridge" Alternative Benefit Plans offered by 4 MCOs. The ABPs include individual cost-sharing responsibilities and a substance use disorder benefit. (<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/new-hampshire-mcp.pdf>)
- **November 20, 2014:** NH submits to CMS its 1115(a) Demonstration Waiver for Premium Assistance. (1115(a) Waiver Application, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-pending-app-11202014.pdf>)
- **March 4, 2015:** The Centers for Medicare and Medicaid Services (CMS) approves NH's mandatory individual Premium Assistance Program requiring the new adult group to enroll in Qualified Health Plans through New Hampshire's Marketplace Exchange, with contingent approval granted through December 31, 2018. (1115(a) Demonstration Approval Letter: https://www.dhhs.nh.gov/pap-1115-waiver/documents/pa_approvalletter.pdf; NHHPP Special Terms and Conditions: https://www.dhhs.nh.gov/pap-1115-waiver/documents/pa_termsandconditions.pdf)
- **January 1, 2016:** The new adult group transitions to the NHHPP PAP. (NHHPP Special Terms and Conditions: https://www.dhhs.nh.gov/pap-1115-waiver/documents/pa_termsandconditions.pdf)
- **April 5, 2016:** The NH legislature reauthorizes the NHHPP through December 2018 (HB 1696) with 100% federal funding continuing through December 31, 2016. HB 1696 includes a work/community engagement requirement. At this time CMS has never approved a work/community engagement requirement. (Version adopted by both bodies as of 3.31.16: https://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2016&v=SP&id=795, Enrolled Bill Amendment as of 4.4.16; https://gencourt.state.nh.us/bill_Status/billtext.aspx?sy=2016&txtFormat=amend&id=2016-1246EBA)
- **August 10, 2016:** NH DHHS seeks an amendment from CMS to the NHHPP that includes a work/community engagement requirement and citizenship documentation requirement. (<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-state-application-081016.pdf>)
- **November 1, 2016:** CMS approves other parts of the amendment submitted on August 10, 2016 but does not approve the work/community engagement requirement and citizenship documentation requirement. (November 1, 2016 Letter, <https://www.medicaid.gov/Medicaid-CHIP-Program->



[Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-cms-response-110116.pdf](#)).

- **June 28, 2017:** The Governor signs HB517 into law as the trailer bill to the biennial budget for SFY 19-SFY20. HB 517 includes a provision that requires NH DHHS to seek a waiver or state plan amendment from CMS in order to establish certain work/community engagement requirements as conditions of eligibility in the NHHPP. (HB 517 Docket, https://gencourt.state.nh.us/bill_Status/bill_docket.aspx?lsr=0676&sy=2017&sortoption=&txtsessioyear=2017&txtbillnumber=hb517; RSA 126-A:5, XXX(a)(1) Commissioner of Health and Human Services, <http://www.gencourt.state.nh.us/rsa/html/X/126-A/126-A-5.htm>)
- **August 30, 2017:** DHHS releases a draft amendment to the PAP including a work/community engagement requirement. At that time, 51,924 individuals were covered as part of the NHHPP, including 41,392 in QHPs and 7,093 in managed care plans as medically frail or opt-outs. (<https://www.dhhs.nh.gov/pap-1115-waiver/documents/hb517-nhhpp-work-reqs-2017.pdf>)
- **October 24, 2017:** NH submits an application to CMS to amend the NHHPP demonstration in order to promote work/community engagement opportunities for PAP participants. (NH Work/Community Engagement application, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-pa3.pdf>)
- **January 11, 2018:** In a letter to state Medicaid Directors CMS announces a new policy that supports 1115(a) demonstration projects where participation in work/community engagement is a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries. (CMS Letter to State Medicaid Directors, RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>)
- **January 12, 2018:** CMS approves Kentucky's 1115(a) demonstration project with an 80 hour per month work/community engagement requirement. (Kentucky Approval Letter from CMS, <http://www.modernhealthcare.com/assets/pdf/CH113894112.PDF>)
- **April 9, 2018:** The Commissioners for the Departments of Information Technology and Health and Human Services sends to the Governor a contract renewal request for continued maintenance of the New HEIGHTs system and a contract amendment to implement necessary enhancements to the New HEIGHTs system. (April 9, 2018 Letter, http://sos.nh.gov/nhsos_content.aspx?id=8589976832)
- **May 2, 2018:** The Executive Council authorizes NH DHHS to engage in enhancements to the New HEIGHTS system in order to facilitate the Granite Advantage program enrollment and verification including for the work/community engagement requirements. (May 2, 2018 Executive Council Consent Calendar #43, http://sos.nh.gov/nhsos_content.aspx?id=8589976832)
- **May 7, 2018:** CMS approves the work/community engagement requirement with implementation no sooner than January 1, 2019. (CMS Work/Community Engagement Approval Letter, <https://www.dhhs.nh.gov/pap-1115-waiver/documents/cms-approval-letter-05072018.pdf>; Special Terms and Conditions for Work/Community Engagement Requirement, <https://www.dhhs.nh.gov/pap-1115-waiver/documents/nh-pap-stcs-05072018.pdf>)
- **May 8, 2018:** NH DHHS issues a notice to amend its waiver in order to discontinue the NHHPP and implement Granite Advantage, providing Medicaid coverage to the expansion population through managed care with a work/community engagement requirement. (Public Notice, <https://www.dhhs.nh.gov/ombp/medicaid/documents/ga-public-notice-2-05042018.pdf>)
 - 1115(a) Demonstration Waiver Extension Application (<https://www.dhhs.nh.gov/ombp/medicaid/documents/ga-waiver-app-05082018.pdf>)



- **May 8, 2018:** NH DHHS issues a notice to amend its Title XIX State Plan to update the Medicaid Alternative Benefit Plan that will be provided to the Medicaid new adult group. (State Plan Amendment Notice, <https://www.dhhs.nh.gov/ombp/medicaid/documents/abp-spa-public-notice-05042018.pdf>)
- **May 10, 2018:** The Senate concurs with house amendments to SB 313, extending coverage for the new adult group through Granite Advantage, terminating the NHHPP and creating the Granite Advantage Program. (Version adopted by both parties as of 5.10.18, https://gencourt.state.nh.us/bill_status/billText.aspx?sy=2018&txtFormat=html&v=HA2&id=1972; Enrolled Bill Amendment dated 5.25.18, https://gencourt.state.nh.us/bill_status/billtext.aspx?sy=2018&txtFormat=amend&id=2018-2086EBA)
- **May 14, 2018:** DHHS hosts a public hearing in Concord, NH and presents at the Medical Care Advisory Committee (MCAC) Meeting. (<https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>)
- **May 24, 2018:** DHHS hosts a public hearing in Nashua, NH. (<https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>)
- **June 5, 2018:** DHHS plans to host a public hearing in Concord, NH. (<https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>)
- **June 7, 2018:** Comments due on the Title XIX State Plan Amendment to update the Medicaid Alternative Benefit Plan that will be provided to the Medicaid new adult group. (<https://www.dhhs.nh.gov/ombp/medicaid/documents/abp-spa-public-notice-05042018.pdf>)
- **June 29, 2018:** Comments due on the 1115(a) Waiver Demonstration extension application. (<https://www.dhhs.nh.gov/ombp/medicaid/documents/ga-abb-public-notice-05302018.pdf>; <https://www.dhhs.nh.gov/ombp/medicaid/documents/ga-public-notice-05302018.pdf>) (Revised from deadline date of June 7, 2018, added to timeline 6.5.18)
- **June 30, 2018:** Deadline for NH DHHS to submit to CMS its 1115(a) Waiver Extension Application and its Title XIX State Plan Amendment. (SB 313, 126-AA:2, I (d)) https://gencourt.state.nh.us/bill_status/billText.aspx?sy=2018&txtFormat=html&v=HA2&id=1972)
- **August 7, 2018:** Approximate deadline NH DHHS must submit to CMS an eligibility and enrollment monitoring plan. (STC #48q, <https://www.dhhs.nh.gov/pap-1115-waiver/documents/nh-pap-stcs-05072018.pdf>)
- **September 2018:** Proposed rules reviewed by the Joint Health Care Reform Oversight Committee, Fiscal Committee, and Medical Care Advisory Committee (MCAC). (Added to timeline 6.5.18)
- **November 15, 2018:** Earliest date for public hearing on proposed rules. (Added to timeline 6.5.18)
- **December 2018:** Final proposal on proposed rules due and presented to the Joint Legislative Committee on Administrative Rules (JLCAR). (Added to timeline 6.5.18)
- **December 1, 2018:** The date by which approvals from CMS must be received for the 1115(a) waiver extension application and the Alternative Benefit Plan state plan amendment in order to keep the Granite Advantage Health Care program from being terminated. (SB 313, 126-AA:2(d), https://gencourt.state.nh.us/bill_status/billText.aspx?sy=2018&txtFormat=html&v=HA2&id=1972)
- **December 31, 2018:** The NHHPP demonstration sunsets. (NHHPP Special Terms and Conditions, https://www.dhhs.nh.gov/pap-1115-waiver/documents/pa_termsandconditions.pdf; NH RSA 126-A:5 XXV <http://www.gencourt.state.nh.us/rsa/html/X/126-A/126-A-mrg.htm>)



- **January 1, 2019:** The earliest date the work/community engagement requirement can go into effect. (Work/Community Engagement Requirement Special Terms and Conditions, <https://www.dhhs.nh.gov/pap-1115-waiver/documents/nh-pap-stcs-05072018.pdf>)
- **January 1, 2019:** The latest date the DHHS Commissioner must submit a plan for the implementation of a fully automated verification system to assess all work/community engagement activities by July 1, 2020. (SB 313, 126-AA:2 IV(c) https://gencourt.state.nh.us/bill_status/billText.aspx?sy=2018&txtFormat=html&v=HA2&id=1972)
- **July 1, 2019:** NH’s new MCO contracts set to begin. (1115(a) Demonstration Waiver Extension Application, <https://www.dhhs.nh.gov/ombp/medicaid/documents/ga-waiver-app-05082018.pdf>)

Which States Have Adopted a “Work/Community Engagement Requirement” for Medicaid?¹

A: Arkansas, Indiana, Kentucky all have CMS approved work/community engagement requirement waivers; while Arizona, Kansas, Maine, Mississippi, Utah, and Wisconsin have applied. NH’s waiver requires the highest number of work hours (100/mo), and applies to a wider age category than Arkansas and Indiana (NH applies to the Medicaid new adult group through age 64). While Indiana and Kentucky’s waivers apply to traditional and expansion adults NH’s work/community engagement requirement would only apply to the new adult group.

Approved and Pending Work Requirement Waivers – Covered Populations and Age Exemptions, as of May 8, 2018										
	AR - approved	AZ	IN - approved	KS	KY - approved	ME	MS	NH - approved	UT	WI
Expansion Adults [^]	X	X	X		X			X		
Traditional Adults [*]			X	X (parents 0-38% FPL)	X	X (parents 0-105% FPL)	X (parents 0- 27% FPL)		X (parents 60-100% FPL; childless adults 0-100% FPL)	X (childless adults 0-100% FPL)
Age Exemptions	50+	55+	60+	65+	65+	65+	65+	65+	60+	50+
Hours Required	80/mth	20/wk	Up to 20/wk	20-30/wk	80/mth	20/wk	20/wk	100/mth	3 consecutive mths of job search/training unless working 30/wk	80/mth

^{*}Other groups such as Transitional Medical Assistance, family planning only, or former foster care youth, may be included in some states.

[^] NC’s amended Section 1115 application, submitted on November 20, 2017, includes provisions (premiums and work requirements) that would affect newly eligible adults *only if proposed state legislation (“Carolina Cares”) is enacted*. These provisions are not reflected in the table, as the state has not yet added this population to its Medicaid program.

¹ <https://www.kff.org/medicaid/issue-brief/which-states-have-approved-and-pending-section-1115-medicaid-waivers/>.



What is the Relationship Between the Work/Community Engagement Requirements in the CMS Approval of May 2018 and the Requirements in SB 313?

A: The STCs prevail for now. As outlined in the timeline, on May 7, 2018, CMS approved the waiver amendment to the NHHPP PAP to include a work/community engagement requirement as submitted in 2017 under prior legislation. The CMS Approval includes special terms and conditions which detail the approved terms for qualifying activities, exemptions, penalties and opportunities for cure, DHHS' implementation plan, etc. However, SB 313 has not been signed into law, and includes a new and revised work/community engagement requirement. Also, DHHS has published a new Granite Advantage 1115(a) Waiver Extension Application. ***So which terms and definitions apply?***

For now, the CMS Approval and STCs of May 2018 apply. First, SB 313 specifically states that the commissioner "shall implement the work and community engagement requirement... in accordance with the terms and conditions of any waiver approved by CMS." In addition, DHHS has noted in its Granite Advantage 1115(a) Waiver Extension Application that "New Hampshire's approved work and community engagement STCs will continue to apply to the Granite Advantage expansion adults throughout the requested waiver extension period, through 2023." See GA Waiver App at 9. Finally, SB 313 notes that if there are differences between the statute and the approved STCs, the commissioner shall provide notice to the governor, House Speaker and Senate President. See SB 313, RSA 126-AA:1, IV.

How Soon Can the Granite Advantage Work/Community Engagement Requirement Go Into Effect?

A: Not until after January 1, 2019. NH's work/community engagement requirement can't be implemented before January 1, 2019 according to the recent waiver approved by CMS. See CMS Waiver Approval Special Terms and Conditions (STCs) May 7, 2018. Pursuant to SB 313, the Commissioner is supposed to implement the work/community engagement requirement beginning January 1, 2019 "in accordance with" the waiver submitted by the Commissioner. See Granite Advantage 1115(a) Waiver Extension Application, May 8, 2018. However, prior to implementation of the work/community engagement requirement DHHS must make certain assurances to CMS and submit an eligibility and enrollment monitoring plan (see details below). The plan is due within 90 days of the waiver approval (or approximately August 7, 2018). The state "may not take adverse action on a beneficiary for failing to complete community engagement requirements until CMS has reviewed and approved [the] eligibility and enrollment monitoring plan for completeness and determined that the state has addressed all of the required elements..." STC 48q.

DHHS is also seeking an extension of the CMS Approval STCs through its pending Granite Advantage Waiver Extension Application as CMS's approval is only valid through December 31, 2018 unless extended or amended.

What Administrative Approvals Must DHHS Secure Prior To Implementation of the Granite Advantage Work/Community Engagement Requirement?

A: A lot! SB 313 requires DHHS to submit all waivers and state plan amendments to CMS by June 30, 2018, and secure approvals prior by December 1, 2018.

DHHS is also in the process of:

- **Granite Advantage 1115(a) Waiver Application Extension:** DHHS is holding hearings on an amended waiver in order to comply with the new Granite Advantage Program requirements set



forth in SB 313, including discontinuing the Premium Assistance Program, extending the work/community engagement requirement CMS Approval STCs, waiving retroactive coverage, amending the alternative benefit plan, implementing an asset test, and including a citizenship documentation requirement.

- **Rulemaking:** Developing rules pursuant to the rulemaking authority in SB 313 in order to implement the new program (see below).
- **Eligibility and Enrollment Plan for CMS:** Developing an eligibility and enrollment monitoring plan as required by CMS.
- **Systems Enhancements:** Enhancing the New HEIGHTS system to include eligibility determinations through an amended contract approved April 2018 (Deloitte Consulting LLP).
- **MCO Contracts and Transition:** Finalizing Medicaid Managed Care Organizations contract re-procurement RFP and model contract in order for the MCO contract “go live” on July 1, 2019. Meanwhile, Granite Advantage will commence January 1, 2019.
- **Alternative Benefit Plan:** Updating the Alternative Benefit Plan for the new Granite Advantage Program.

[What Other Waivers or Coverage Requirements is DHHS Seeking as Part of the Granite Advantage Program Through the Granite Advantage 1115\(a\) Waiver Extension Application?](#)

A: DHHS’s Granite Advantage 1115(a) Waiver Extension Application seeks to extend the NHHPP demonstration waiver (the PAP Waiver) renewal period in order to implement work/community engagement requirements for the Medicaid expansion/Granite Advantage adults, deny eligibility to applicants who are unable to verify US citizenship through 2 forms of identification or prove NH residency, and enable the state to consider an asset test.

The Granite Advantage 1115(a) Waiver Extension Application clarifies what aspects of the current demonstration waiver will or will not be continued. For example:

- All individuals in the expansion new adult group will receive benefits through Granite Advantage including the medically frail (unless they qualify for employer coverage through HIPP).
- NH seeks to extend its waiver of retroactive coverage for expansion adults.
- Granite Advantage applicants will be required to provide all necessary information regarding financial eligibility, assets, residency, citizenship or immigration status and insurance coverage to the department.
- Granite Advantage beneficiaries are required to inform the department of any changes in status.
- NHHPP will end, beneficiaries will be transitioned to MCOs on January 1, 2019, and then again on July 1, 2019, giving beneficiaries a window for choosing an MCO and then using auto-assignment.
- The Alternate Benefit Plan (ABP) for Granite Advantage will align with the State Plan, including LTSS.
- Cost sharing for expansion adults over 100% FPL will be discontinued.
- New healthy behavior and cost effectiveness provisions will be included in the new managed care program.



- Granite Advantage enrollees will have to meet the work/community engagement requirements set forth in the CMS Waiver Approval STCs regarding necessary hours of engagement, exemptions, qualifying activities, penalties and reactivation of coverage.
- NH seeks to extend the waiver of the requirement to provide three months retroactive coverage to expansion adults.
- NH predicts that although it is projected to spend \$535 million on NHHPP in CY 2018 (federal and state), it will spend between \$354.8 million to \$398.1 million a year with Granite Advantage.
- NH outlines the key elements of its work/community engagement monitoring program and evaluation criteria.

How Much Time is a Granite Advantage Beneficiary Given to Meet the Work/Community Engagement Qualifying Activity or Exemption?

A: Beneficiaries are enrolled based on income eligibility and have at least 75 days of eligibility before having to meet the work/community engagement requirements or an exemption. All currently enrolled beneficiaries will have 75 calendar days after otherwise being determined eligible for Medicaid Expansion to meet the work/community engagement requirement. See May 7 STC 47b. This 75-day period applies to those beneficiaries who are currently enrolled when the work/community engagement requirement begins, those determined eligible after the start date, and those who reapply after their eligibility has been terminated. Beneficiaries must begin to meet the work/community engagement “qualifying activity” requirement beginning with **the first full month following any applicable 75-day notice period.**

What is the Work/Community Engagement Requirement for Granite Advantage Enrollees? What are the “Qualifying Activities”?

A: The work/community engagement requirement mandates that non-exempt Granite Advantage enrollees engage in “qualifying activities” for at least 100 hours a month.

In brief, a member of the new adult group must, by the end of the first full month after the 75 day notice period, demonstrate that he or she is engaging in at least 100 hours per month (based on an average of 25 hours a week) of certain activities including: work for public or private sector, on-the-job training, job skills training including at a NH college or university, vocational skills training (up to 12 months), job search activities, high school or high school equivalency, public or community service, caregiver services, or drug treatment.

Pursuant to CMS May 7 Approval STC 45, beneficiaries without an exemption must document their participation in any one or a combination of the “qualifying activities”, attest to compliance, and report changes in circumstances.

*45. **Qualifying Activities.** Beneficiaries without an exemption must document their participation in any one or a combination of qualifying activities by attesting compliance with the community engagement requirements and reporting applicable changes in circumstances in accordance with 42 CFR 435.916(c). NHHPP Premium Assistance beneficiaries may satisfy their community engagement requirements through a variety of activities, including but not limited to:*



- *Unsubsidized employment;*
- *Subsidized private or public sector employment;*
- *Subsidized or unsubsidized employment at a non-profit organization;*
- *On the job training;*
- *Job skills training related to employment;*
- *Enrollment at an accredited community college, college or university that is counted on a credit hour basis;*
- *Job search and readiness assistance, including but not limited to job training or job search activities that are required in order to receive unemployment benefits; and other job training related services, such as job training workshops and time spent with employment counselors, offered by the department of employment security;*
- *Vocational educational training not to exceed 12 months with respect to any individual;*
- *Education directly related to employment, in the case of a recipient who has not received a high school diploma or certificate of high school equivalency;*
- *Attendance at a secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate;*
- *Participation in substance use disorder treatment;*
- *Community service and public service;*
- *Caregiving services for a non-dependent relative or other person with a disabling health, mental health, or developmental condition; or*
- *Participation in and compliance with Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) employment requirements.*

SB 313, 126-AA:2 III (a) *Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:*

- (1) *Unsubsidized employment including by nonprofit organizations.*
- (2) *Subsidized private sector employment.*
- (3) *Subsidized public sector employment.*
- (4) *On-the-job training.*
- (5) *Job skills training related to employment, including credit hours earned from an accredited college or university in New Hampshire. Academic credit hours shall be credited against this requirement on an hourly basis.*
- (6) *Job search and job readiness assistance, including, but not limited to, persons receiving unemployment benefits and other job training related services, such as job training workshops and time spent with employment counselors, offered by the department of employment security. Job search and job readiness assistance under this section shall be credited against this requirement on an hourly basis.*
- (7) *Vocational educational training not to exceed 12 months with respect to any individual.*
- (8) *Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency.*



(9) Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.

(10) Community service or public service.

(11) Caregiver services for a nondependent relative or other person with a disabling medical or developmental condition.

(12) Participation in substance use disorder treatment.

How Many Hours Must a Non-Exempt Granite Advantage Beneficiary Engage in Qualifying Activities?

The CMS Approval STCs require non-exempt beneficiaries to participate in one or more qualifying activities for at least 100 hours a month. Beneficiaries may be required to provide supporting documentation. DHHS must provide beneficiaries with disability reasonable modifications to meeting the requirements and an equal opportunity to participate. See CMS Approval STC 46. SB 313 requires non-exempt beneficiaries in the Granite Advantage Program to be engaging in at least 100 hours a month, based on 25 hours per week, in one or more qualifying activities.

Who is Exempt From the Work/Community Engagement Requirement and When and How Do They Demonstrate Such an Exemption?

A: Granite Advantage beneficiaries who are part of an “exempt population” are not required to meet the work/community engagement requirement to maintain eligibility. These exempt populations, as outlined in the STCs, include beneficiaries who are: ill or incapacitated, in a state-certified drug court program, a necessary caretaker or a caretaker of a dependent child under 6 years old or a disabled child, pregnant or less than 60 days post-partum, medically frail, disabled or residing with an immediate family member who is disabled, hospitalized, seriously ill, or residing with an immediate family member who is hospitalized or seriously ill, exempt from SNAP or TANF employment requirements, or enrolled in NH’s voluntary Health Insurance Premium Program (HIPP).

STC 44, <https://www.dhhs.nh.gov/pap-1115-waiver/documents/nh-pap-stcs-05072018.pdf>).

- Beneficiaries who are temporarily unable to participate due to illness or incapacity as documented by a licensed provider;
- Beneficiaries who are participating in a state-certified drug court program;
- Beneficiaries who are a parent or caretaker where care of a dependent is considered necessary by a licensed provider;
- Beneficiaries who are a custodial parent or caretaker of a dependent child under 6 years of age (only applies to one parent or caretaker in case of a 2-parent household);
- Beneficiaries who are a parent or caretaker of a dependent child of any age with a disability;
- Beneficiaries who are pregnant or 60 days or less post-partum;
- Beneficiaries identified as medically frail;
- Beneficiaries with a disability as defined by the ADA, Section 504, or Section 1557, who are unable to comply with the requirements due to disability-related reasons;
- Beneficiaries residing with an immediate family member who has a disability as defined by the ADA, Section 504, or Section 1557, who are unable to meet the requirement for



reasons related to the disability of that family member;

- *Beneficiaries who experience a hospitalization or serious illness;*
- *Beneficiaries residing with an immediate family member who experiences a hospitalization or serious illness;*
- *Beneficiaries who are exempt from Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) employment requirements; or*
- *Beneficiaries who are enrolled in New Hampshire's voluntary Health Insurance Premium Program (HIPP).*

SB 313 (126-AA:2 III (d))

(d) This paragraph shall not apply to:

- *A person who is unable to participate in the requirements under subparagraph (a) due to illness, incapacity, or treatment, including inpatient treatment, as certified by a licensed physician, an advanced practice registered nurse (APRN), a licensed behavioral health professional, a licensed physician assistant, a licensed drug and alcohol counselor (LADAC), or a board-certified psychologist. The physician, APRN, licensed behavioral health professional, licensed physician assistant, LADAC, or psychologist shall certify, on a form provided by the department, the duration and limitations of the disability.*
- *A person participating in a state-certified drug court program, as certified by the administrative office of the superior court.*
- *A parent or caretaker as identified in RSA 167:82, II(g) where the required care is considered necessary by a licensed physician, APRN, board-certified psychologist, physician assistant, or licensed behavioral health professional who shall certify the duration that such care is required.*
- *A custodial parent or caretaker of a dependent child under 6 years of age or a child with developmental disabilities who is residing with the parent or caretaker; provided that the exemption shall only apply to one parent or caretaker in the case of a 2-parent household.*
- *Pregnant women.*
- *A beneficiary who has a disability as defined by the Americans with Disabilities Act (ADA), section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and is unable to meet the requirement for reasons related to that disability; or who has an immediate family member in the home with a disability under federal disability rights laws and who is unable to meet the requirement for reasons related to the disability of that family member, or the beneficiary or an immediate family member who is living in the home or the beneficiary experiences a hospitalization or serious illness.*
- *Beneficiaries who are identified as medically frail, under 42 C.F.R. section 440.315(f), and as defined in the alternative benefit plan and in the state plan and who are certified by a licensed physician or other medical professional to be unable to comply with the work and community engagement requirement as a result of their condition as medically frail. The department shall require proof of such limitation annually, including the duration of such disability, on a form approved by the department.*
- *Any beneficiary who is in compliance with the requirement of the Supplemental Nutritional Assistance Program (SNAP) and/or Temporary Assistance to Needy Families (TANF) employment initiatives.*



Are the STC Exempt Populations the Same as Those Listed in SB 313?

A: **No.** The STCs, however, incorporate all of the exempt populations listed in SB 313, and in addition, add as exempt populations those who are 60 days or less post-partum, exempt from SNAP and/or TANF work/community engagement requirements, or a caretaker to a child of any age with a disability. See STC 44 as compared to SB 313, 126-AA:2 III (d).

What Happens if a Granite Advantage Beneficiary is Not in Compliance with the Work/Community Engagement Requirement?

A: Eligibility will be suspended for beneficiaries who fail to meet the month's required work/community engagement hours unless s/he "cures" the non-compliance in the following month or appeals the suspension prior to its effective date. If the noncompliance is not cured (see below) then the state will suspend eligibility the first day of the month following the month the beneficiary had to cure. Suspension remains in effect until the noncompliance is cured or the beneficiary falls into an exempt population. If the suspension is not cured the state will send the beneficiary a notice for a redetermination period. During the redetermination period eligibility will be terminated if the beneficiary is not in compliance with the work/community engagement hours. See May 7 STC 47c, e.

How Does a Beneficiary "Cure" Work/Community Engagement Non-Compliance?

A: Granite Advantage beneficiaries who do not meet the work/community engagement hours in a given month will be given one month to "cure" the non-compliance. Beneficiaries can "cure" the non-compliance by demonstrating a "good cause" excuse as to why the hours were not met, demonstrating he or she falls into an exemption population and thus the work/community engagement hours do not apply, or by making up the deficient hours from the previous month *in addition to* satisfying the required hours for the current month. A notice sent by the state at the beginning of the month will notify the beneficiary of his or her responsibility to cure.

When Does "Good Cause" Excuse a Granite Advantage Beneficiary's Failure to Meet the Work/Community Engagement Requirement Hours?

A: If a Granite Advantage beneficiary can show the Commissioner "good cause" exists to excuse him or her from the failure to engage in qualifying activities to meet the required work/community engagement requirements for the month, then the beneficiary will remain eligible for benefits and will not be required to make up the hours in the following month. "Good cause" includes, but is not limited to situations where in the month of non-compliance the beneficiary: has a disability or resides with an immediate family member with a disability, is hospitalized, seriously ill, or resides with an immediate family member who was hospitalized or seriously ill, experiences a birth or death of a family member, experiences severe weather, has a family emergency or life-changing event, or experiences another good cause as approved by the state. See May 7 STC 47c.

The CMS Waiver Approval specifically defines "good cause" in STC 47b as:

- *The beneficiary has a disability as defined by the ADA, section 504, or section 1557, and was unable to meet the requirement for reasons related to that disability, but was not exempted from community engagement requirements;*
- *The beneficiary resides with an immediate family member who has a disability as*



defined by the ADA, section 504, or section 1557, and was unable to meet the requirement for reasons related to the disability of that family member, but was not exempted from community engagement requirements;

- *The beneficiary experienced a hospitalization or serious illness, but was not exempted from community engagement requirements*
- *The beneficiary resides with an immediate family member who experienced a hospitalization or serious illness, but the beneficiary was not exempted from community engagement requirements;*
- *The beneficiary experiences the birth, or death, of a family member residing with the Beneficiary;*
- *The beneficiary experiences severe inclement weather (including natural disaster) and therefore was unable to meet the requirement;*
The beneficiary has a family emergency or other life-changing event (e.g., divorce or domestic violence); or
- *Other good cause reasons as defined or approved by the state.*

SB 313 states (126-AA:2 III (b)):

“An individual may apply for good cause exemptions which shall include, at a minimum, the following verified circumstances:

- *The beneficiary experiences the birth, or death, of a family member living with the beneficiary.*
- *(2) The beneficiary experiences severe inclement weather, including a natural disaster, and therefore was unable to meet the requirement.*
- *The beneficiary has a family emergency or other life-changing event such as divorce.*
- *The beneficiary is a victim of domestic violence, dating violence, sexual assault, or stalking consistent with definitions and documentation required under the Violence Against Women Reauthorization Act of 2013 under 24 C.F.R. section 5.2005 and 24 C.F.R. section 5.2009, as determined by the commissioner pursuant to rulemaking under RSA 541-A.*
- *The beneficiary is a custodial parent or caretaker of a child 6 to 12 years of age who, as determined by the commissioner on a monthly basis, is unable to secure child care in order to participate in qualifying work and other community engagement either due to a lack of child care scholarship or the inability to obtain a child care provider due to capacity, distance, or another related factor.*

Are the STC “Good Cause” Excuses the Same as Those Listed in SB 313?

A: No. The STCs add to the SB 313 list of “good cause” excuses where the beneficiary has a disability or resides with an immediate family member who has a disability as defined by the ADA, or was hospitalized, seriously ill, or resides with an immediate family member who was hospitalized or seriously ill. Although the STCs include domestic violence as an example of a “family emergency” or “life-changing event” considered a “good cause” excuse, it does not list “domestic violence” in its own category, as SB 313 does, and does not mention dating violence, sexual assault, and stalking, all of which are found in SB 313. It is possible, however, that dating violence, sexual assault, and stalking could fall under “family emergency” or “life changing event” just as “domestic violence” does. See STC 47c compared to SB 313, 126-AA:2 III (b).



What are the Assurances the State Must Make to CMS Prior to Implementation of the Work/Community Engagement Requirement?

A: CMS is requiring DHHS to develop an eligibility and enrollment monitoring plan assuring CMS that it can meet all the requirements around eligibility, enrollment and disenrollment set forth in the CMS Approval STCs before requiring any beneficiary comply with the work/community engagement requirements.

More specifically, the CMS Approval STC 48 requires the state to do the following prior to implementation of the work/community engagement requirement:

- a. Maintain system capabilities to operationalize both the suspension of eligibility and the lifting of suspensions once community engagement requirements are met.*
- b. Maintain mechanisms that would stop payments to QHPs when a beneficiary's eligibility is suspended and to trigger payments once the suspension is lifted.*
- c. Ensure that there are processes and procedures in place to seek data from other sources, including SNAP and TANF, and systems to permit beneficiaries to efficiently report community engagement hours or obtain an exemption, in accordance with 42 CFR 435.907(a), 435.916(c), and 435.945, and to permit New Hampshire to monitor compliance.*
- d. Ensure that there are timely and adequate beneficiary notices provided in writing, including but not limited to:*
 - i. When the community engagement requirement will commence for that specific beneficiary;*
 - ii. Whether a beneficiary is exempt, how the beneficiary must indicate to the state that she or he is exempt, and under what conditions the exemption would end;*
 - iii. The specific number of community engagement hours per month that a beneficiary is required to complete, and when and how the beneficiary must report participation;*
 - iv. A list of the specific activities that may be used to satisfy community engagement requirements and a list of the specific activities that beneficiaries can engage in to cure an impending suspension or termination of eligibility, as described in STC 45;*
 - v. Information about resources that help connect beneficiaries to opportunities for activities that would meet the community engagement requirement, and information about the community supports that are available to assist beneficiaries in meeting community engagement requirements;*
 - vi. Information about how community engagement hours will be counted and documented;*
 - vii. What gives rise to a suspension or a termination of eligibility, what a suspension or termination would mean for the beneficiary, and how to avoid a suspension or termination, including how to apply for good cause and what kinds of circumstances might give rise to good cause;*
 - viii. If a beneficiary is not in compliance for a particular month, that the beneficiary is out of compliance, and how the beneficiary can cure the non-compliance in the immediately following month, including the specific number of hours needed to cure the noncompliance;*
 - ix. If a beneficiary's eligibility is suspended or terminated, how to appeal the suspension or termination;*



- x. How to lift a suspension if the beneficiary is suspended, including the specific number of community engagement hours that must be completed to lift the suspension;*
- xi. How to reapply if a beneficiary's eligibility is terminated during redetermination;*
- xii. Any differences in the program requirements that individuals will need to meet in the event they transition off of SNAP or TANF but remain subject to the community engagement requirements of this demonstration; and*
- xiii. If a beneficiary has sought to demonstrate good cause, whether good cause has been approved or denied, with an explanation of the basis for the decision and how to appeal a denial.*
- e. Ensure application assistance is available to beneficiaries (in person and by phone).*
- f. Ensure that specific activities that may be used to satisfy community engagement requirements and specific activities that would allow beneficiaries to cure an impending suspension or termination of eligibility (as described in STC 45) are available during a range of times and through a variety of means (e.g., online, in person) at no cost to the beneficiary.*
- g. Maintain an annual redetermination process, including systems to complete ex parte redeterminations and use of notices that contain prepopulated information known to the state, consistent with all applicable Medicaid requirements.*
- h. Maintain ability to report on and process applications in-person, via phone, via mail and electronically;*
- i. Provide full appeal rights as required under 42 CFR, Part 431, subpart E prior to suspension or termination of eligibility, and observe all requirements for due process for beneficiaries whose eligibility will be suspended, denied, or terminated for failing to meet the community engagement requirement, including allowing beneficiaries the opportunity to raise additional issues in a hearing, including whether the beneficiary should be subject to the suspension or termination, and provide additional documentation through the appeals process.*
- j. Assure that termination, disenrollment, or denial of eligibility will only occur after an individual has been screened and determined ineligible for all other bases of Medicaid eligibility and reviewed for eligibility for insurance affordability programs in accordance with 435.916(f).*
- k. Establish beneficiary protections, including assuring that NHHPP Premium Assistance beneficiaries do not have to duplicate requirements to maintain access to all public assistance programs that require community engagement and employment.*
- l. Make good faith efforts to connect NHHPP Premium Assistance beneficiaries to existing community supports that are available to assist beneficiaries in meeting community engagement requirements, including available non-Medicaid assistance with transportation, child care, language access services and other supports.*
- m. Make good faith efforts to connect beneficiaries with disabilities as defined in the ADA, Section 504, or Section 1557 with services and supports necessary to enable them to meet community engagement requirements. The existence of separate programs and services providing such supports does not relieve the state of its obligation to provide reasonable modifications for people with disabilities with respect to its Medicaid community engagement requirements.*
- n. Ensure the state will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions from the community engagement requirements and/or additional mitigation strategies, so that the community engagement requirements will not be unreasonably burdensome for*



beneficiaries to meet.

o. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable modifications related to meeting community engagement requirements.

p. Maintain a system that provides reasonable modifications related to meeting the community engagement requirement to beneficiaries with disabilities as defined in the ADA, Section 504, or Section 1557.

q. The state must submit an eligibility and enrollment monitoring plan within 90 calendar days after approval of the community engagement amendment of this demonstration. CMS will work with the state if it determines changes are necessary to the state's submission, or if issues are identified as part of its review. Once approved, the eligibility and enrollment monitoring plan will be incorporated into the STCs as an Attachment. The state will provide status updates on the implementation of the eligibility and enrollment monitoring plan in the quarterly reports. Should the state wish to make additional changes to the eligibility and enrollment monitoring plan, the state should submit a revised plan to CMS for review and approval. The state may not take adverse action on a beneficiary for failing to complete community engagement requirements until CMS has reviewed and approved eligibility and enrollment monitoring plan for completeness and determined that the state has addressed all of the required elements in a reasonable manner.

r. The State makes the general assurance that it is in compliance with protections for beneficiaries with disabilities under the ADA, Section 504, and Section 1557.

s. Plan Requirements. At a minimum, the eligibility and enrollment monitoring plan will describe the strategic approach and detailed project implementation plan, including metrics, timetables, and programmatic content to ensure processes are in place where applicable, for defining and addressing how the state will comply with the assurances described in these STCs. Where possible, metrics baselines for the following data points will be informed by state data, and targets will be benchmarked against performance in best practice settings:

- i. Number and percentage of beneficiaries who are exempt from the community engagement requirement;*
- ii. Number and percentage of beneficiaries granted good cause from community engagement requirements;*
- iii. Number and percentage of beneficiaries who requested reasonable accommodations;*
- iv. Number and percentage and type of reasonable accommodations provided to beneficiaries;*
- v. Number and percentage of beneficiaries whose eligibility was suspended for failing to comply with community engagement requirements;*
- vi. Number and percentage of beneficiaries whose eligibility was terminated at redetermination for not meeting community engagement requirements;*
- vii. Number and percentage of community engagement-related appeal requests;*
- viii. Number, percentage and type of community engagement good cause requested;*
- ix. Number, percentage, and type of community engagement good cause granted; and*
- x. Number and percentage of applications made in-person, via phone, via mail and electronically.*

[Will DHHS Draft Rules Regarding the Work/Community Engagement Requirement?](#)

A: Yes. DHHS must go through the rulemaking process on several topics pursuant to RSA 541-A with public hearings in order to adopt rules about the work/community engagement requirement implementation. Pursuant to RSA 126-AA:2, III(b),(e) and RSA 126-AA:2, VIII, DHHS must submit the proposed rules first to the Joint Health Care Reform Oversight Committee (RSA 161:11) and then to the



fiscal committee of the general court before submitting the rules to the Joint Legislative Committee on Rules (JLCAR).

What will the Rules Adopted by the Commissioner Pursuant to SB 313 Address?

A: The rulemaking authority in SB 313 requires the Commissioner of DHHS to adopt rules pertaining to the community engagement requirement, “good cause” determinations, opportunity to cure and reactivation following non-compliance.

Pursuant to SB 313, the Commissioner must adopt rules pertaining to the community engagement requirement (RSA 126-AA:2, III(e):

- (1) *Enrollment, suspension, and disenrollment procedures in the program;*
- (2) *Verification of compliance with community engagement activities.*
- (3) *Verification of exemptions from participation.*
- (4) *Opportunity to cure and re-activation following noncompliance, including not being barred from re-enrollment.*
- (5) *Good cause exemptions.*
- (6) *Education and training of enrollees.*
- (7) *Annual certification of medical frailty pursuant to 42 C.F.R. section 440.315(f), including proof and duration of such condition on a form supplied by the department.*

The rules must be consistent with the work/community engagement waiver approved by CMS on May 7, 2018.

The Commissioner must also adopt rules pertaining to the determination of “good cause” and other exemptions to termination. See SB 313, RSA 126-AA:2, III(b). Included in this rulemaking is the specific obligation of the Commissioner to define when a beneficiary is “a victim of domestic violence, dating violence, sexual assault, or stalking consistent with definitions and documentation required under the Violence Against Women Reauthorization Act of 2013 under 24 CFR section 5.2005 and 24 CFR section 5.2009.” SB 311, RSA 126-AA:2, III (b)(4).

Finally, under the Granite Advantage program, anyone receiving health coverage benefits is responsible for providing information regarding his or her change in status or eligibility, including current contact information. The Commissioner must adopt rules pertaining to the opportunity to cure and for reactivation following noncompliance.

What Type of Resources Will Be Available to Support Beneficiaries Around Enrollee Status, Exemptions and Qualifying Activities?

A: It is unclear. DHHS “will work collaboratively with its contracted MCOs to monitor work/community engagement qualifying activities, exemptions and enrollee status, including through MCO collection of enrollee-reported information, State verification of enrollee and MCO reported information, and over time, a State-developed automated verification system.” See Granite Advantage Waiver at 9; See also details on Granite Workforce pilot program below.

DHHS entered into an amended contract in May 2018 to allow the New HEIGHTS system to support the Granite Advantage Program and assist with communications during the transition from NHHPP to Granite Advantage, as well as manage program exemptions, “good cause”, activity tracking, compliance



management, reporting and communication. Enhancements to the system are anticipated to do the following: “Based on the information that has been gathered through eligibility, an individual will programmatically be set as Exempt, Deemed to Satisfy or Mandatory.... Once determined, an individual’s status information will be accessible through the Customer Service Dashboard and Granite Advantage participation management screens in New HEIGHTS.” See <http://sos.nh.gov/WorkArea/DownloadAsset.aspx?id=8589976760> at 11. A new module is planned to provide “the ability to search for individual participants, manage exemptions, “good cause”, and activities.” *Id.*

In addition, system enhancements are planned to include activity tracking through NH EASY to allow “participants in the Granite Advantage Healthcare Program to self-manage. Through responsive design, individuals will be able to view their participation summary, request exemptions and “good cause”, and track activities through a PC tablet or mobile device.”

[What Type of Work Support Services Will Be Available to Support Enrollees with Qualifying Activities?](#)

A: SB 313 provides for a pilot Granite Workforce program to support Granite Advantage enrollees and provide subsidies for employers.

SB 313 uses allowable federal funds from TANF to provide employment services (no cash assistance) and to provide subsidies to employers in high need areas to remove barriers to work for low income families. Applicants are eligible for Granite Workforce if they are also enrolled in the New Hampshire Granite Advantage Health Care Program. The program is to be established in cooperation with the Department of Employment Security.

[What Will The Benefits Look Like for Individuals Transitioning From the NHHPP PAP to Managed Care through the Granite Advantage Program?](#)

A: NH is seeking permission from CMS to update the Alternative Benefit Plan (ABP) for the new adult group in the Granite Advantage program to align with the State Plan. This alignment will include long term care services and supports (LTSS) for those who meet the functional assessment requirements. The ABP will be updated to include all the essential health benefits to the extent it doesn’t currently.

NH DHHS has posted a public notice that it’s amending its State Plan to update the Medicaid Alternative Benefit Plan (ABP) that will be provided to the Medicaid new adult group through the Granite Advantage program.

According to the ABP Public Notice (<https://www.dhhs.nh.gov/ombp/medicaid/documents/abp-spa-public-notice-05042018.pdf>), the proposed ABP state plan amendment seeks to align the benefit package for the new adult group with the Medicaid State Plan benefit package. The Department also plans to amend its cost sharing state plan to align copayments for the expansion population with those for other Medicaid eligibility categories. “Under the Affordable Care Act, members of the new adult group (adults with income below 138 percent of the federal poverty level, ages 19 to 64, who are not pregnant, and not eligible or enrolled in Medicare) will receive an alternative benefit package that must include the 10 Essential Health Benefits. These EHB’s include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder



services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. The State will assure compliance with 42 CFR 440.345 to provide full access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for individuals in the expansion population who are under age 21 as required by law and regulation, and consistent with current state policy regarding the delivery of these services. Any EPSDT services not included in the Medicaid managed care plan benefit package will be provided through the State's fee-for-service Medicaid program. Other covered services will include medically necessary services as prior authorized, as well as other services required to be covered pursuant to state or federal law, regulation or policy." The State will describe the process to access these benefits in notices sent to all individuals receiving the alternative benefit package. Comments are due on the revised ABP to the Department by Thursday, June 7, 2018.

[Is Someone Certified as Medically Frail under NHHPP Required to Participate in the Work/Community Engagement Requirement Under the Granite Advantage Program?](#)

A: **It is unclear.** A Granite Advantage beneficiary who is identified as medically frail and certified by a licensed physician or other medical professional as unable to comply with the work/community engagement requirement as a result of his or her condition as medically frail (under [42 CFR 440.315\(f\)](#)) is exempt from the work/community engagement requirement. SB 313 126-AA:2 III (d); STC 44. NH DHHS, however, will institute a process to determine whether an individual is considered medically frail. STC 19. Certification as medically frail must occur on an annual basis. SB 313, 126-AA:2 III (d).