

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: New Hampshire
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name:	Valerie King	Position/Title:	Administrator I, NH DHHS-OMB
Name:	Kathleen Dunn	Position/Title:	Director, NH DHHS-OMB
Name:	Marilee Nihan	Position/Title:	Financial Manager, NH DHHS-OMB

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Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101(a)(1)); (42 CFR 457.70):

1.1.1 Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

1.1.2. Providing expanded benefits under the State’s Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Descriptions of the requirements specified in Sections 3, 4, 6, 7, 8, 11 and 12 of this State Plan are incorporated by references through the State Medicaid plan.

1.1.3. A combination of both of the above. (Section 2101(a)(2))

1.1-DS The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2 Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

<i>State Plan</i>	<i>Phase 1 - Title XIX expansion:</i>	
	<i>Effective/Implementation Date:</i>	<i>May 1, 1999</i>
<i>SPA #1</i>	<i>Phase 2 - Title XXI</i>	
	<i>Effective/Implementation Date:</i>	<i>January 1, 1999</i>
<i>SPA #2</i>	<i>Adding “good-cause” exceptions</i>	
	<i>Effective/Implementation Date:</i>	<i>April 1, 2002</i>
<i>SPA #3</i>	<i>Increasing premiums</i>	
	<i>Effective/Implementation Date:</i>	<i>January 1, 2003</i>
<i>SPA #4</i>	<i>Adding a tiered drug formulary</i>	
	<i>Effective/Implementation Date:</i>	<i>January 1, 2005</i>

- SPA #5 *Increasing premiums*
 Effective/Implementation Date: October 1, 2009
- Change in healthcare MCO*
 Effective/Implementation Date: July 1, 2009
- Enrollment cap authority*
 Effective/Implementation Date: October 1, 2009
- Citizenship documentation*
 Effective/Implementation Date: January 1, 2010
- SPA #6 *Increasing co-payments*
 Effective/Implementation Date: January 3, 2011
- SPA #7 *FQHC wrap around*
 Effective/Implementation Date: October 1, 2009 (see narrative)
- Orthodontic wrap around*
 Effective/Implementation Date: July 1, 2011
- SPA #8 *Convert from a Combination to a Medicaid Expansion*
 Effective/Implementation Date: July 1, 2012

1.4- TC Tribal Consultation (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Not Applicable - New Hampshire does not have any recognized tribes.

Section 2. General Background and Description of Approach to Children’s Health Insurance Coverage and Coordination

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified, by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

See the American Community Survey data as analyzed by the University of Minnesota's State Health Access Data Assistance Center (SHADAC), found at <http://www.shadac.org/datacenter>. Please note the sample size for race/ethnicity is too small to ensure reliable interpretations of the data.

2.2. Health Services Initiatives- Describe if the State will use the health services initiative option as allowed at **42 CFR 457.10**. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR

457.10)

New Hampshire does not intend to use the health services initiative option.

- 2.3 TC Tribal Consultation Requirements- (Sections 1902(a)(73) and 2107(e)(1)(C)) ; (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act)** requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children’s Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

Not Applicable - New Hampshire does not have any recognized tribes.

Section 3. Methods of Delivery and Utilization Controls

- Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan, and continue on to Section 4.
- 3.1. Delivery Standards** Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))
- Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS’ Regional Office for review and approval.

(Section 2103(f)(3))

- 3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102)(a)(4) (42CFR 457.490(b))

Section 4. Eligibility Standards and Methodology

4.0. **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group:

Prior to transitioning to a full Medicaid Expansion program, New Hampshire's CHIP was administered as a combination program. The program consisted:

- *Medicaid Expansion for children under the age of 1 whose family income is greater than 185 and at or below 300% FPL. These children were enrolled in Medicaid (Healthy Kids Gold)*
- *Separate CHIP which offered coverage to children who are between age 1 and under the age of 19 whose family income is from 186% to 300% FPL. This program was called Healthy Kids Silver*

Effective July 1, 2012, New Hampshire converted its "combined" program into a complete Medicaid Expansion program covering children 0 to 18 years of age in families with income up to 300% FPL. At this time there is no other public health or state only insurance program for children in New Hampshire.

4.1. **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

- 4.1.0 Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.
- 4.1.1 Geographic area served by the Plan if less than Statewide:
- 4.1.2 Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:
4.1.2.1-PC Age: _____ through birth (SHO #02-004, issued November 12, 2002)
- 4.1.3 Income of each separate eligibility group (if applicable):
4.1.3.1-PC 0% of the FPL (and not eligible for Medicaid) through _____% of the FPL (SHO #02-004, issued November 12, 2002)
- 4.1.4 Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):
- 4.1.5 Residency (so long as residency requirement is not based on length of time in state):
- 4.1.6 Disability Status (so long as any standard relating to disability status does not restrict eligibility):

- 4.1.7 Access to or coverage under other health coverage:
- 4.1.8 Duration of eligibility, not to exceed 12 months:
- 4.1.9 Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

4.1.9.1 States should specify whether Social Security Numbers (SSN) are required.

4.1.9.2 Continuous eligibility

4.1-PW **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

4.1- LR **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1993(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

- (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
- (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) An alien who belongs to one of the following classes:
 - (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
 - (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending

applicants for TPS who have been granted employment authorization;

(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;

(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(vi) Aliens currently in deferred action status; or

(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

Elected for pregnant women.

Elected for children under age ____.

4.1.1-LR The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.1-DS **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only

supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2. Assurances The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

- 4.2.1. These standards do not discriminate on the basis of diagnosis.
- 4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.
- 4.2.3. These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS Supplemental Dental Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

- 4.2.1-DS These standards do not discriminate on the basis of diagnosis.
- 4.2.2-DS Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3-DS These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3 Methodology. Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102(b)(2)) (42CFR, 457.350)

4.3.1 Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(4)) (42CFR, 457.305(b))

Check here if this section does not apply to your State.

NH currently has no waiting list. Enrollment may be limited in the future if state general fund appropriation is insufficient. The need to implement an enrollment cap is assessed as follows: the Department monitors current or "actual" CHIP monthly enrollment. If actual enrollment grows to within range of a predetermined member month number, (as representing enrollment that couldn't be supported financially by State funds if it were to continue to grow at that sustained annual growth rate), that member month number would be considered a "trigger" for capping enrollment (meaning that no additional children will be enrolled).

A wait list will be established to accept children determined to be eligible. The list will be queued on as first come, first served. Since NH has a joint application for Medicaid and CHIP, the application and eligibility determination process continue during the CHIP enrollment cap and wait list period. Families determined to be eligible for Medicaid are enrolled and those determined to be eligible for CHIP are informed of the enrollment cap and their children placed on the wait list. While on the CHIP wait list, families must continue to report changes that effect eligibility such as income or household composition. If eligibility redetermination of a family on the CHIP wait-list results in eligibility for Medicaid, the children are enrolled in Medicaid and taken off the wait list. Enrollment is tracked monthly. Potential enrollment spaces become available at the end of each month when enrollment ends for currently enrolled children who disenroll because they

- 1. Have turned 19;*
- 2. Become eligible for Medicaid coverage;*
- 3. Move out of state;*
- 4. Failed to complete redetermination process;*
- 5. Were determined ineligible during redetermination process;*
- 6. Moved within the state with no forwarding address;*
- 7. Voluntarily disenrolled with no stated reason;*
- 8. Died.*

When enrollment "slots" become available, a specified number of children (equal to number of slots available) at the top of the wait list are contacted, and their families informed that they may enroll. Children are removed from the wait list and families are provided 30 days to enroll.

4.3.2. Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

4.3.3-EL Express Lane Eligibility Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update

sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

4.4 Eligibility screening and coordination with other health coverage programs

States must describe how they will assure that:

- 4.4.1. only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102)(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.
- 4.4.2. children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102)(b)(3)(B)) (42CFR, 457.350(a)(2))
- 4.4.3. children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR, 431.636(b)(4))
- 4.4.4. the insurance provided under the State child health plan does not substitute for

coverage under group health plans; states should check the appropriate box.
(Section 2102)(b)(3)(C)) (42CFR, 457.805) (42CFR 457.810(a)-(c))

4.4.4.1. (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined.

4.4.5 Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

Under Medicaid Expansion, the CHIP enrollees will join their "traditional" Medicaid counterparts in NH Medicaid. New Hampshire will continue to utilize a single application, regardless of whether the individual qualifies through Title XIX or Title XXI. The appropriate FMAP will be applied, but there will be no other visible differentiation between children who qualify under Title XXI and those who qualify under Title XIX.

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The same unit (within the Department) determines eligibility for both CHIP and Medicaid. This maximizes the coordination of eligibility for both programs. As part of the determination process, Department staff verifies an applicant's current enrollment status through New HEIGHTS, New Hampshire's eligibility system. Staff then determine, based on the information collected as part of the application process, which program, if any, the child is eligible for, and assist the family in the enrollment of the child into the applicable program. Staff checks for eligibility with Medicaid first. If the child is eligible, he/she is enrolled. If the child is not found eligible for Medicaid, he/she will be screened.

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There are no recognized tribes in New Hampshire; therefore, the state does not have any specific policies in place targeting American Indians for Alaskan Natives, as defined by 42 CFR 457.10. Tribal members receive the same outreach as other sectors of the population. There is currently no cost-sharing requirement for this program. If after January 1, 2014, New Hampshire chooses to assess a premium or other cost sharing measures on its Title XXI population, protections will be in place for American Indians and Alaskan Natives.

4.4-EL

The State should designate the option it will be using to carry out screen and enroll requirements:

The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State

for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

5.1. (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42CFR 457.80(b))

5.1.1. (formerly 2.2.1.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

Applications are available at a variety of community agencies and provider sites such as hospitals, WIC sites, and public health clinics and community health centers funded through Title V and Title X grants. These same agencies are part of an on-going effort by the state to identify Medicaid eligible children and provide support to eligible families who up until now have not availed themselves of Medicaid benefits but would be eligible if they applied.

Community Application Assistors are located in various hospitals and community health centers around the state. These assistors have been trained in the eligibility requirements for various public health and state benefit programs, and along with other community partners (e.g. school nurses), educate consumers and support them as they navigate the application process.

The Department will also be utilizing its internal assets as "ambassadors" to help promote the program and identify eligible participants. These assets include the following organizations: the Bureau of Child Care Licensing, the Women Infants and Children program, the Child Development Bureau, Minority Health, the NH Employment Security's Rapid Response program (which educates the recently unemployed about their options for health coverage following a lay off), the State Library, and community TV and school nurses located across the state. The Department will also be making information available to community organizations, including materials in Spanish (some materials also available in Bosnian)

Formal Medicaid application and intake sites include the eleven local New Hampshire district offices strategically located around the state. In addition, the Medicaid 800-P short forms can be completed and submitted via the Title

V agencies, Title X clinics, WIC sites, disproportionate share hospitals, Early Intervention sites and Federally Qualified Health Centers (FQHC's).

An application can also be completed and submitted on-line through NH Easy at <https://nheasy.nh.gov>. Since January of 2011, The New Hampshire Electronic Application System (NH EASY) has offered NH residents a fast and easy way to apply online for cash, medical, Child Care, Medicare Savings Program, and/or Food Stamp benefits.

The Department also maintains a toll free phone number and client service units in both the Office of Medicaid Business and Policy and the Division of Family Assistance (DFA) to provide prompt answers to questions regarding eligibility and services.

- 5.1.2.** (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

New Hampshire's CHIP had previously been administered as a combination program. The "separate" portion of the program (Healthy Kids Silver) was administered through a public private partnership with New Hampshire Healthy Kids Corporation. This partnership was dissolved effective June 30, 2012, when the State converted to a full Medicaid Expansion Program.

- 5.2.** (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. Section 2102(a)(3) and 2102(c)(2) and 2102(b)(3)(E))(42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts - particularly new enrollment outreach efforts will be coordinated with and improve upon existing State efforts described in Section 5.2.

The state coordinates enrollment and outreach efforts with other public programs and private health insurance programs and child health agencies in order to increase the number of children with creditable health coverage.

As part of their contract with the state, Title V agencies must screen all children they see at their agencies for health insurance. If that child is uninsured, agency staff is required to assist families in applying for the program.

When an applicant indicates on the form that a child in the family has special health care needs that require ongoing supports to remain at home, that person's name and information is sent to Family Voices, a family to family health information and resource project, who will assist that family with the coordination of other private and state resources for children with special health care needs such as the Special Medical Services Bureau, a Title V funded program.

Also, the New HEIGHTS software program, which utilizes a cascading logic, allows Department staff to screen eligibility for various Medicaid coverage groups as well as other public assistance

programs.

5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

5.3 Strategies

Section 6. Coverage Requirements for Children's Health Insurance

- Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.
- 6.1.** The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))
- 6.1.1.** Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)
- 6.1.1.1.** FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)
- 6.1.1.2.** State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.1.3.** HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.2.** Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.
- 6.1.3.** Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

- 6.1.4.** Secretary-approved Coverage. (**Section 2103(a)(4)**) (**42 CFR 457.450**)
 - 6.1.4.1.** Coverage the same as Medicaid State plan
 - 6.1.4.2.** Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver
 - 6.1.4.3.** Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population
 - 6.1.4.4.** Coverage that includes benchmark coverage plus additional coverage
 - 6.1.4.5.** Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)
 - 6.1.4.6.** Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)
 - 6.1.4.7.** Other (Describe)

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

- 6.2.1.** Inpatient services (Section 2110(a)(1))
- 6.2.2.** Outpatient services (Section 2110(a)(2))
- 6.2.3.** Physician services (Section 2110(a)(3))
- 6.2.4.** Surgical services (Section 2110(a)(4))
- 6.2.5.** Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6.** Prescription drugs (Section 2110(a)(6))
- 6.2.7.** Over-the-counter medications (Section 2110(a)(7))
- 6.2.8.** Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9.** Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10.** Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11.** Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))

- 6.2.12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13. Disposable medical supplies (Section 2110(a)(13))
- 6.2.14. Home and community-based health care services (See instructions) (Section 2110(a)(14))
- 6.2.15. Nursing care services (Section 2110(a)(15))
- 6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17. Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
- 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. Case management services (Section 2110(a)(20))
- 6.2.21. Care coordination services (Section 2110(a)(21))
- 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23. Hospice care (Section 2110(a)(23))
- 6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. Medical transportation (Section 2110(a)(26))
- 6.2.27. Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.28. Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

6.2-DC Dental Coverage (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT¹) codes are included in the dental benefits:

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1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

- State-developed Medicaid-specific
- American Academy of Pediatric Dentistry
- Other Nationally recognized periodicity schedule
- Other (description attached)

6.2.2-DC Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT² codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)Page - 11 – State Health Official

6.2.2.3-DC HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

6.3 The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Describe: Previously 8.6

6.4 Additional Purchase Options- If the State wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. **Cost Effective Coverage-** Payment may be made to a State in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

6.4.1.3. The coverage must be provided through the use of a community based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section

2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2. **Purchase of Family Coverage-** Describe the plan to purchase family coverage. Payment may be made to a State for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

6.4.2.2. The State assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The State assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

Yes
 No

As of July 1, 2012, all children enrolled in NH Medicaid under Title XXI eligibility may apply for the Health Insurance Premium Payment (HIPP) program, NH §1906 enrollment assistance for group health plans. This program was unavailable to the State's CHIP population prior to Medicaid Expansion, however, after July 1, 2012, all CHIP eligible children have access to this premium subsidy offering

The HIPP program defers medical costs from the NH Medicaid program by reimbursing certain Medicaid recipients' private or employer-related group health insurance premiums when it is cost effective. An individual who is eligible for any of the various Medicaid programs and is enrolled in an employer provided health insurance plan may be eligible to participate in the HIPP Program. The HIPP Program will assist in paying the employees share of the employer provided health insurance premium or employer provided cobra insurance for the Medicaid eligible individuals if the insurance premium is less than paying the medical expenses under Medicaid. If the premium is more then the Medicaid average cost for services provided to the Medicaid member, then the member will not be eligible for HIPP.

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6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan.

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State’s process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State’s outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA: Purchasing Pool- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

- Yes
- No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State’s CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA Notice of Availability of Premium Assistance- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

Section 7. Quality and Appropriateness of Care:

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

- 7.1.1. Quality standards
- 7.1.2. Performance measurement
 - 7.1.2 (a) CHIPRA Quality Core Set
 - 7.1.2 (b) Other
- 7.1.3. Information strategies
- 7.1.4. Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)

- 7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))
- 7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))
- 7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))
- 7.2.4 Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

Section 8. Cost-Sharing and Payment

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505)
Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

- 8.1.1.** Yes
8.1.2. No, skip to question 8.8.
8.1.1-PW Yes
8.1.2-PW No, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

- 8.2.1.** Premiums:
8.2.2. Deductibles:
8.2.3. Coinsurance or copayments:
8.2.4. Other:

8.2-DS **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

- 8.2.1-DS** Premiums:
8.2.2-DS Deductibles:
8.2.3-DS Coinsurance or copayments:
8.2.4-DS Other:

8.3 Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42CFR 457.505(b))

8.4 The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. Cost-sharing does not favor children from higher income families over lower

- income families. (Section 2103(e)(1)(B)) (42CFR 457.530)
- 8.4.2.** No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)
- 8.4.3** No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))
- 8.5** Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))
- 8.6** Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)
- 8.7** Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))
- 8.7.1** Provide an assurance that the following disenrollment protections are being applied:
- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.
 - The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
 - In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
 - The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))
- 8.8.** The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))
- 8.8.1.** No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
 - 8.8.2.** No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section

- 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))
- 8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)
- 8.8.6. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

- 9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

New Hampshire already has an impressively low rate (4.7%) of un-insured children. Although the Department has made great strides to remove barriers, many children who are eligible for Medicaid coverage remain uninsured. In an effort to capture these remaining children, New Hampshire has concentrated its efforts toward specific populations, such as teenagers, a group with higher rates of un-insurance. The Department also continues to work toward improving appropriate utilization as well as retention of those children who are enrolled in CHIP and Medicaid.

By converting to a Medicaid Expansion program, New Hampshire expects to increase enrollment and retention of its CHIP eligible population. Cost sharing (in the form of premiums and co-pays) and participation in “other” insurance are believed to have been significant factors that chilled participation in CHIP under the “combination” program model. Both of these barriers will be eliminated under the “expansion” model, which in turn is expected to result in increased enrollment, longer periods of continuous enrollment, appropriate utilization and the elimination of coverage gaps for those children who move between the CHIP and Medicaid programs.

In addition to these improvements, New Hampshire has also focused outreach activities toward increasing enrollment, and appropriate use of benefits among the state’s adolescent population. In New Hampshire, 5.8% of 13-18 year olds are uninsured, as opposed to 4.8% of children ages 6-12 years and 4.3 of children 0-5 years old. Teens living on their own are uninsured at an even higher rate of 13%. NH expects this number to drop once outreach activities are underway.

- 9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

Performance Goal #1: Increase the average length of continuous enrollment by 3-months.
Performance Measure#1: Compare the average length of continuous enrollment before and after the expansion
Data Source: New Heights/MMIS

Performance Goal #2: Increase the number of adolescents (ages 13-19 years) enrolled by 1%.
Performance Measure #2: Compare the number and percent of adolescents enrolled as of June 30, 2012 to those enrolled as of December 31, 2012.
Data Source: New Heights/MMIS

- 9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Data sources for determining New Hampshire's performance include: Census data, the Department's New Heights (eligibility) and MMIS (claims) systems, as well as the NH CHIS commercial database.

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The Department will use a mix of HEDIS and non-HEDIS measures, and limits its measures to those that can be calculated use claims data. The Department does not have the capability to calculate performance for those measures that require medical chart review. Performance measures that the Department routinely assesses include:

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- Access to primary care practioners
- Well child visits
- Adolescent well-care visits
- Annual dental visit
- Appropriate testing for children with pharyngitis
- Appropriate treatment for children with upper respiratory infection
- Emergency Department use - Total
- Emergency Department use - Conditions potentially treatable in primary care

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. Immunizations
- 9.3.7.2. Well childcare

- 9.3.7.3. Adolescent well visits
- 9.3.7.4. Satisfaction with care
- 9.3.7.5. Mental health
- 9.3.7.6. Dental care
- 9.3.7.7. Other, list: see above

9.3.8. Performance measures for special targeted populations.

9.4. The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

Reporting will be complicated by the fact that NH Medicaid will be converting to a Managed Care system beginning in 2013. As a result, the New Hampshire may not have a full 12 months of data collection on FFS. This could result in data that is not compatible or comparable to data obtained for these measures under the combined" CHIP program.

9.5. The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

The Office of Medicaid Business and Policy (OMBP) is responsible for completing the Annual CHIP report (a.k.a. CARTS). The data needed to complete the report is gathered from several entities throughout the Department. A staff member will gather, analyze and draft a report of the data. The draft is reviewed and approved by upper managed within OMBP prior to uploading the information to CMS via the on-line reporting system.

9.6. The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

9.7. The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.135)

- 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. Section 1132 (relating to periods within which claims must be filed)

- 9.9.** Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

Below is a list of the outreach efforts that the Department undertook internally and externally to involve the community/public in the transition of the separate CHIP to the NH Medicaid expansion model.

- 9.9.1** Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

There are not Indian Tribes or organizations in the State of New Hampshire.

- 9.9.2** For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

The conversion to an expanded Medicaid program does not eliminate or restrict eligibility (it expands benefits), implement new cost-sharing, increase the length of existing requirements for un-insurance, or establish wait listing, caps or close enrollment periods. Therefore, the amendment does not fall under the requirements of 42 CFR 457.65(b)-(d). That said, the administration transition was the subject of tremendous public involvement. (see 9.9 Response Generally)

- 9.10** Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
 - Assumptions on which the budget is based, including cost per child and expected enrollment.
 - projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc. All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to

- pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
 - Total 1-year cost of adding prenatal coverage
 - Estimate of unborn children covered in year 1

CHIP Budget

STATE:	FFY Budget	FFY Budget
Federal Fiscal Year	2012	2013
State's enhanced FMAP rate	65%	65%
Benefit Costs	\$15,714,417	
Insurance payments		
Managed care		
<i>per member/per month rate</i>	\$199.25	\$144.56
Fee for Service	\$6,113,296	\$16,910,058
Health Services Initiatives		
Cost of Proposed SPA changes		
Total Benefit Costs	\$21,827,713	\$16,910,058
(Offsetting beneficiary cost sharing payments)		
Net Benefit Costs	\$21,827,713	\$16,910,058
Administration Costs		
Personnel	\$387,786	\$397,481
General administration	\$173,225	\$177,556
Contractors/Brokers		\$250,000
Claims Processing		
Outreach/marketing costs	\$67,841	\$67,841
Other		
Total Administration Costs	\$628,852	\$892,878
10% Administrative Cap	\$2425,301	\$1,878,895
Federal Share	65%	65%
State Share	35%	35%

Total Costs of Approved CHIP Plan _____

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: General Funds

Section 10. Annual Reports and Evaluations

10.1. Annual Reports. The State assures that it will assess the operation of the State plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. The progress made in reducing the number of uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. The State assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-DC Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

The State of New Hampshire will continue to report information regarding the dental benefit package and a list of enrolled dental providers with capacity to accept new patients for posting on the IKN! website.

Section 11. Program Integrity (Section 2101(a))

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.

11.1. The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

- 11.2.1. 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. Section 1128A (relating to civil monetary penalties)
- 11.2.5. Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

- Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan.
- 12.1. Eligibility and Enrollment Matters-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.
- 12.2. Health Services Matters-** Describe the review process for health services matters that comply with 42 CFR 457.1120.
- 12.3. Premium Assistance Programs-** If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.