

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

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

**MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE 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 State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State 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:	<i>Joyce Butterworth</i>	Position/Title: <i>SCHIP Coordinator, NH DHHS-Office of Health Planning and Medicaid</i>
Name:	<i>Lisa Swenson</i>	Position/Title: <i>Assistant Director, NH DHHS-Office of Health Planning and Medicaid</i>
Name:	<i>John Fransway</i>	Position/Title: <i>Finance Director, NH DHHS-Office of Health Planning and Medicaid</i>

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, N2-14-26, Baltimore, Maryland 21244.

Effective Date: May 1998

Approval Date: September 1998

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

- 1.1.1 Obtaining coverage that meets the requirements for a separate child health program (Section 2103); **OR**
- 1.1.2. Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
- 1.1.3. A combination of both of the above.

New Hampshire's expansion of children's health care coverage under Title XXI occurred in two phases, which involved providing expanded benefits under the State's Medicaid plan and obtaining coverage that meets the requirements for a State Children's Health Insurance Program.

In Phase I, implemented May 1998, the state expanded Medicaid to include newborns and infants from birth to age 1 with family income greater than 185% and equal to or less than 300% of FPL. Income is calculated in the same manner currently used by the state for poverty level children (children with family income at or below 185% of FPL) with an additional disregard of 65% of the FPL for the family size involved as revised annually in the Federal Register. In no case will income be disregarded such that the resulting net income is less than or equal to 185% FPL. The federal eligibility standard is 235% FPL.

In Phase II, implemented in January 1999, the New Hampshire Department of Health and Human Services (DHHS) partnered with the New Hampshire Healthy Kids Corporation (NHHKC) to provide insurance coverage through the development of a State Children's Health Insurance Program (SCHIP) for children ages 1 through 18 with family income greater than 185% and equal to or less than 300% of FPL. Income is calculated in the same manner currently used by the state for poverty level children (children with family income at or below 185% of FPL) with an additional disregard of 65% of the FPL for the family size involved as revised annually in the Federal Register. In no case will income be disregarded such that the resulting net income is less than or equal to 185% FPL. The federal eligibility standard is 235% FPL.

1.2 Please 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))

Effective Date: Phase 1: May 1998, Phase 2: Jan. 1999

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No expenditures were claimed prior to time the state had the legislative authority to operate the State plan or plan amendment as approved by CMS.

- 1.3 Please 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)

New Hampshire's SCHIP complies with all applicable civil rights requirements, including the above-mentioned sites.

- 1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Effective date: Phase 1 –May 1998
Phase 2 –January 1999

Implementation date: Phase 1 –May 1998
Phase 2 –January 1999

State Plan Amendment #1 (phase 2) Effective Date: January 1, 1999

State Plan Amendment #2 (Compliance SPA) Effective Date: August 24, 2002

State Plan Amendment #3 (cost sharing changes) Effective Date: January 1, 2003

Effective Date: *Phase 1: May 1998, Phase 2: Jan. 1999*

Approval Date: *September 1998*

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

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

See electronically attached, Health Resources and Services Administration New Hampshire State Planning Grant Interim Report, March 2002

- 2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

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

Brochures outlining options for health care coverage, including Medicaid eligibility as well as Medicaid application forms (New Hampshire has a short application form commonly referred to as the 800-P for poverty level children's groups and pregnant women) 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. The state provides Medicaid application forms and information on the voluntary managed care health plans to NHHKC for distribution to families whose children are likely to be Medicaid eligible.

Formal Medicaid application and intake sites include the twelve local New Hampshire DHHS 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).

The state's voluntary Medicaid managed care option is offered by trained staff at the Managed Care Unit staff at the NH- DHHS state office. The Managed Care Unit functions as enrollment counselors, offering the option to enroll in managed care (versus remaining in the fee-for-service program), explaining the rules, providing state-approved marketing packages developed by the health plans, and enrolling recipients who choose this option.

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

At this time there is no other public health or state only insurance program for children.

2.2.2 The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

The only health insurance program for children that involves a public private-partnership is New Hampshire Healthy Kids Corporation (NHHKC). In 1993, the New Hampshire Legislature passed the Healthy Kids Act (RSA 126:H) to address the growing problem of uninsured children. The Act created the New Hampshire Healthy Kids Corporation, a private non-profit, "deemed to be a public instrumentality and ... by the authority of the powers conferred by this chapter shall be deemed and held to be the performance of public and essential government functions of the state."

The state does not subsidize premiums at this time, but it provides funds for administration, marketing and outreach. NHHKC is governed by a seventeen member Board of Directors that includes six appointees of state government including the Department of Health and Human Services. State oversight includes a requirement for an annual report to the Governor, various Commissioners, and members of the Legislature.

The state created NHHKC to provide affordable health coverage and access to health care services for uninsured children. The program design and operations are consistent with the goals of Title XXI. As a public-private partnership, the goal has been to conduct multifaceted outreach and marketing, simplify the enrollment process, and design and operate a program that would avoid the stigma often associated with Medicaid.

NHHKC's plan provides comprehensive health and dental benefits, which emphasize the preventive and primary care that children need to stay healthy and go to school ready to learn. Currently coverage is underwritten by Anthem Blue Cross Blue Shield of New Hampshire for health benefits and mental health benefits, and Northeast Delta Dental for dental benefits. Selection of the insurance carrier was conducted through a formal RFP process and contracts are renegotiated annually.

To be eligible for Healthy Kids, a child must be a full time resident of the state, not eligible for Medicaid, not enrolled in employment-related group health insurance in the past three months, and their family income cannot exceed 400% of the federal poverty level.

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Efforts to identify and enroll children in NHHKC have been extensive. The Corporation has developed outreach partnerships with schools, childcare agencies, health care providers, municipalities and community-based social service agencies. Award-winning printed materials include postcards, posters, annual reports, brochures and flyers, which are widely distributed and displayed throughout the state. The Corporation conducts an aggressive media campaign, which has resulted in frequent coverage in newspapers, on radio and television; speaking engagements on public affairs programs, and public service announcements. The Corporation teams with businesses for promotion activities such as fast food tray liners and promotion cards stuffed in bags at retail outlets such as grocery stores, pharmacies and discount department stores.

Schools provide the largest source of referral (about 40%) where twice each year the school age population is blanketed with promotion information and school nurses display information and make direct referrals. Twenty percent of inquiries cite media as their source of information about the program. As the program becomes more well known, provider and word-of-mouth referrals are becoming more frequent. The Corporation tracks response to its various marketing and outreach activities for informed decision making about the most effective methods and messages. At the present time NHHKC estimates that it has reached over 12,000 families in New Hampshire.

- 2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and 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. *(Previously 4.4.5.)*

(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

The state coordinates SCHIP enrollment and outreach efforts with other public and private health insurance programs and child health agencies in order to increase the number of children with creditable health coverage. This coordination reduces duplication of efforts and provides quality health care coverage to New Hampshire's uninsured children.

As demonstrated in section 4.4, the state closely coordinates SCHIP enrollment efforts with the state's Medicaid program. The state's Division of Family Assistance (DFA) utilizes a software program called New HEIGHTS in the district offices. The program utilizes a cascading logic that allows staff in the district offices to screen for eligibility for various Medicaid coverage groups as well as other public assistance programs. With the advent of Title XXI, efforts were taken to incorporate the logic required to automate the screening and eligibility referrals of Healthy Kids Silver to NHHKC. Referrals are also automated to NHHKC for families whose income exceeds 300% FPL and do not qualify for services funded by Title XIX or XXI, but may qualify for the unsubsidized Healthy Kids Silver Buy-In program.

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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. As part of their health performance measurements, Title V agencies are also expected to document clients who are enrolled in the Healthy Kids program. The Department's SCHIP coordinator also meets with Maternal and Child Health coordinators on a regular basis to discuss problems and coordinate efforts.

In addition, at the time of implementation of SCHIP, plans were made to provide for the screening, referral and tracking of children with special health needs. A question on the Healthy Kids application (800P) asks, "Are there any children with special health care needs who require ongoing supports to maintain their care at home?". If the applicant checks off yes, 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.

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Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

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. 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))

As noted in Section 1.1.3 and described in the state's Medicaid state plan amendment, Phase 1 of the NH's State Children's Health Insurance Program consists of the state using Title XXI funds to expand Medicaid coverage for newborns and infants from birth to age 1 with family income greater than 185% and equal to or less than 300% of FPL. To complement Phase 1, the state instituted a name change to all children's Medicaid programs to Healthy Kids Gold in an effort to reduce barriers due to stigma associated with Medicaid enrollment. The Medicaid expansion program is also called Healthy Kids Gold and infants on this program receive Medicaid benefits until they turn 1.

Under the Healthy Kids Gold Medicaid expansion program, families have the option of enrolling their child in the fee-for-service program, in which case the infant will receive the current Medicaid benefits package; or the family can choose to enroll the infant in the existing Medicaid voluntary managed care program, contracted through Anthem Blue Cross Blue Shield of New Hampshire. One of the goals in providing coverage for infants through a Medicaid expansion is to provide infants with a rich and comprehensive benefits package to meet their complex needs during the first year of life. The focus is on preventive and well-child care to give the child a healthy start.

Utilizing the provisions of Title XXI the state offers retroactive coverage, for infants at greater than 185% FPL and equal to or less than 300% FPL. Consistent with the current Medicaid fee-for-service program, the state will provide 3 months of retroactive coverage for services received in the 3 months prior to application date for Healthy Kids as long as the services received are within the scope of benefits and as long as the infant met the eligibility requirements during those 3 months.

Through Phase 2 of NH's SCHIP plan, the state provides insurance coverage to children between ages 1 and 19 whose family income is greater than 185% and equal to or less than 300% of FPL. The state purchases insurance for these children through NHHKC. To be consistent with Phase I, this program is called Healthy Kids Silver.

NHHKC subcontracts with Anthem Blue Cross Blue Shield of New Hampshire and Northeast Delta Dental. The coverage offered is a managed care product with a focus on preventive and well-child care. NHHKC selected Anthem Blue Cross Blue Shield and Northeast Delta Dental via a competitive bid process. Contracts have been renegotiated annually until November

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2001 when the contracts were negotiated for 18 months. The state will not require another competitive bid process until such time as their enrollment reaches a sufficient capacity to support a competitive bid process.

The Healthy Kids Silver benefits package includes an emphasis on perinatal care coverage for pregnant adolescent girls not previously served by NHHKC. The state bears full risk for the maternity benefit and carries out a cost settlement after the adolescent has reached sixty (60) days postpartum.

Mental health benefits are accessed through a phone call to the Blue Cross Blue Shield Behavioral Health Network. Prior PCP authorization is not necessary to access the mental health or dental benefits.

At the time of enrollment for Healthy Kids Silver, a family chooses a primary care provider (PCP) from the Blue Cross Blue Shield provider network. If a PCP is not chosen, the family is contacted by NHHKC. and assisted with the selection process. The family also needs to submit the first month's premium, which is collected by NHHKC on behalf of the state.

Utilizing the provisions under Title XXI the state has implemented cost sharing provisions Healthy Kids Silver. Families whose income is greater than 185% and equal to or less than 250% of FPL pay a \$25 per child per month premium, and there is a \$100 cap on monthly premiums for these families with multiple children. Families whose income is greater than 250% and equal to or less than 300% of FPL pay a \$45 per child per month premium, and there is a \$135 cap on monthly premiums for these families with multiple children. NHHKC has made the premium payment process as user friendly as possible including mailing labels, change of address forms, use of coupon books. NHHKC implemented voluntary participation in electronic funds transfer (EFT) for premium payment in Fall 2002.

Defaulting on the payment of premiums result in the termination of eligibility after 60 days except for pregnant teens. NHHKC reports to the state children whose eligibility is terminated and the circumstances of the termination. NHHKC and the state can waive premium payment for hardship/good cause as described in section 8.7. NHHKC supports a premium rescue fund through which charitable dollars are used to help families overcome a temporary loss of income or unexpected financial crisis.

Pregnant teens do not have their eligibility terminated for failure to pay premiums until after the postpartum period. The default clock begins on the sixty-first (61st) day postpartum. Terminating health care coverage mid-pregnancy is counter productive to the state's goal of healthy birth outcomes for mother and infant.

In addition to the monthly premium for Healthy Kids Silver, a \$10 co-pay for office visits, \$5 for generic prescriptive drugs, and \$10 for brand name drugs is required along with a \$50 fee for emergency room visits, unless the patient is admitted to the hospital. Providers will be responsible for collecting the co-pays at the time of service. The office co-pay will not apply to well-child or preventive health visits, and any covered dental services.

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The state includes in its contract with NHHKC, provisions for quality assurance, and data and reporting requirements as outlined in the section 7.0 and 9.0 of this application.

- 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))

The state bears the responsibility for utilization control for the Healthy Kids Gold fee for service program. For the Healthy Kids Gold voluntary managed care program, the managed care organization, Anthem Blue Cross Blue Shield, conducts utilization reviews with state oversight.

The primary utilization control for Healthy Kids Silver is the responsibility of the managed care organization, Anthem Blue Cross Blue Shield of New Hampshire. The contract with Anthem includes a definition of medical necessity and utilization management requirements, including clinical staffing requirements. The plan is required to have written utilization management policies and procedures that include appropriateness criteria for authorization and denial of services and protocols for prior approval, hospital discharge planning, and retrospective review. All of the aforementioned is currently in place in the Medicaid voluntary managed care contract and is applied to children covered under Title XXI.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

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 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

- 4.1.1. Geographic area served by the Plan: *Statewide*
- 4.1.2. Age: *For Phase I, Healthy Kids Gold -Medicaid expansion: Infants up to age 1.
For Phase II, Healthy Kids Silver: Children between age 1 and 19.*
- 4.1.3. Income: *Family income must be greater than 185% and equal to or less than 300% of the FPL. (Income is calculated in the same manner as currently used by the state for poverty level children -children with family income at or below 185% of FPL-with an additional disregard of 65% of the federal poverty level for the family size involved as revised annually in the Federal Register. In no case will income be disregarded such that the resulting net income is less than or equal to 185% FPL. The federal eligibility standard is 235% FPL.) Methods for evaluating income include paycheck stubs, W-2s, income tax returns and letters from employers on company letterhead.*
- 4.1.4. Resources (including any standards relating to spend downs and disposition of resources): *There is no resource or assets test*
- 4.1.5. Residency (so long as residency requirement is not based on length of time in state):
To be eligible a child must be a resident of the State of New Hampshire. There is no time requirement to be considered a resident.
- 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:
Children who are covered under a group health plan or other health insurance coverage, or are children of a public employee eligible for coverage under a state health benefits plan are not eligible for the Healthy Kids Silver. An application for Healthy Kids Silver will be disapproved if it is determined that the child was covered under a health insurance plan within the last six months. However, an application may be approved for good cause. Such reasons include: loss of employment, change of employment to an employer who does not provide dependent coverage, death of the employed parent, discontinuation of coverage to all employees (regardless of income) by the employer, insurer

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closes its operation in New Hampshire, an involuntary reduction in work hours that no longer allows the employee to enroll the employees dependent children under the employer's health plan, voluntary loss of employment and the loss occurred for any of the good cause reasons specified in New Hampshire Code of Administrative Rules He-W 910.09(c) (2)a-g, cases of domestic violence, a temporary insurance policy is ending, COBRA coverage if good cause existed when employer coverage was lost, loss of coverage beyond the control of custodial parent when non-custodial parent drops insurance, and loss of coverage when parent leaves work to be the primary caretaker for his/her children ages 5 and under (effective April 1, 2002).

4.1.8.

Duration of eligibility:

In general, a child who has been determined eligible for Healthy Kids Gold or Silver shall remain eligible unless the child attains the upper age limit, as appropriate, is no longer a resident of the state, or fails to pay premiums (for Healthy Kids Silver). Exceptions to this policy are previously noted.

The state may determine that an enrollee is not eligible if eligibility was a result of making a false statement, misrepresentation or concealment of or failure to disclose income or health insurance coverage. The state may recover payments made by the state on behalf of enrollees as a result of any false statement, misrepresentation, etc. regarding income or health insurance coverage.

Eligibility is re-determined not more than 12 months after the effective date of eligibility and annually thereafter.

4.1.9.

Other standards (identify and describe): *The state asks for a social security number on the Healthy Kids application. The social security number is required only for Healthy Kids Gold.*

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 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.

4.2.3.

These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment.

(Section 2102)(b)(2) (42CFR 457.350)

With the implementation of SCHIP, the state created a single application, the 800P, for both Healthy Kids Silver and Healthy Kids Gold programs. Families can apply for the Healthy Kids program by visiting their local DHHS District Office, or by mailing the application

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directly to the mail- in enrollment center located at NHHKC.

By Federal regulation, only state employees are permitted to make eligibility determinations. DFA case technicians at the local district office and at NHHKC are responsible for screening all applications and verifying income, age, and other eligibility requirements. Information collected on the application form, include name, address, date of birth, social security number, residency, citizenship, family income, employment, and insurance (both current and in the previous six months).

If information is incomplete or questionable, the state will attempt to contact the applicant by phone to obtain missing information or to clarify questionable information within 10 business days of receipt of the application. If the family does not have access to a phone and/or if the state is not able to make contact by phone, the state will attempt to contact the family by mail. If no response is obtained within 10 days of sending a letter, the application will be denied.

The state will test for Medicaid eligibility first before determining eligibility for Healthy Kids Silver. If a child meets Medicaid eligibility, he/she will be enrolled in Healthy Kids Gold (Medicaid). This includes the option of enrolling in the voluntary managed care program. If the family is interested in enrolling in the voluntary managed care program, they need to contact the Managed Care Unit at DHHS.

If a child is not eligible for Medicaid but meets eligibility requirements for Healthy Kids Silver (including income, residence, and insurance requirements), he/she will be enrolled in Title XXI via NHHKC. If a child is not eligible for either program but may be eligible for the non-subsidized Healthy Kids Silver Buy-In program, a referral is made to NHHKC.

Eligibility information for children determined eligible for Healthy Kids Silver will be entered into New HEIGHTS and sent to NHHKC. NHHKC will complete enrollment, including sending a letter notifying the family of the child's eligibility (including the effective date), materials about NHHKC and the health plan and a coupon payment book for premiums. Eligibility will be effective the date a child is enrolled in a plan and payment received. This will generally be the first day of the month after the child was determined eligible but may be later if eligibility is determined within one week of the end of the month, if the premium is not received or if the family takes additional time to select a plan (if and when there is a choice of plans) or primary care provider.

Not more than 12 months after the effective date of eligibility and annually thereafter, the state will re-determine eligibility for Healthy Kids Silver and Healthy Kids Gold. The state will mail a form to enrollees to obtain information necessary to review eligibility. Enrollees will be required to notify NHHKC of any change in circumstance that could affect continued eligibility for coverage. If a child is no longer eligible for Healthy Kids Silver, he/she will be disenrolled. If he/she is eligible for Medicaid, he/she will be enrolled in Healthy Kids Gold. If a child is no longer eligible for Healthy Kids Gold, he/she will be disenrolled. If that child is eligible for Silver, NHHKC will receive an electronic referral and the above-mentioned process will occur to enroll the family in Healthy Kids Silver.

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The state also facilitates the enrollment of uninsured children through its presumptive eligibility program for Healthy Kids Gold. Presumptive eligibility has been enhanced so that presumptive eligibility and community facilitated applications, processed by qualified entities that are authorized and trained by the DHHS, will be centralized at the mail-in enrollment center at NHHKC.

4.3.1. Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

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

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))

As noted in section 4.3, the state determines eligibility for both Healthy Kids Silver and Healthy Kids Gold. As part of the determination for Healthy Kids Silver, the state verifies that an applicant is not a Medicaid beneficiary through New HEIGHTS, the states eligibility system. If the child is not a Medicaid beneficiary, the state will (based on the information collected as part of the application process) determine whether he/she may be eligible for Medicaid (e.g., because of income level). If the child is already enrolled in Medicaid, the application for Healthy Kids Silver will be denied. If the child appears likely to be eligible for Medicaid, the state will determine eligibility and assist in the enrollment of the child into Healthy Kids Gold (Medicaid).

The application includes questions about insurance coverage. If a child has insurance coverage, he/she will not be eligible to receive coverage under Healthy Kids Silver. Also, if a child has had insurance coverage in the past six months and does not meet one of the good cause exemptions (as noted in section 4.1.7), he/she will not be eligible to receive coverage via Healthy Kids Silver. Children who were enrolled in NHHKC prior to the state's Title XXI program and who met the remaining eligibility guidelines were grandfathered into Healthy Kids Silver.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102(b)(3)(B)) (42CFR 457.350(a)(2))

The same state unit determines eligibility for both Healthy Kids Silver and Healthy

Kids Gold (Medicaid), which maximizes the coordination of eligibility for both programs. The state will first determine whether or not a child is eligible for Healthy Kids Gold. If the child is eligible, he/she will be enrolled. Only if he/she is not eligible for Healthy Kids Gold will he/she be screened and enrolled in Healthy Kids Silver via NHHKC.

- 4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

The same state unit determines eligibility for both Healthy Kids Silver and Healthy Kids Gold (Medicaid), which maximizes the coordination of eligibility for both programs. The state will first determine whether or not a child is eligible for Healthy Kids Gold. If the child is eligible, he/she will be enrolled. Only if he/she is not eligible for Healthy Kids Gold will he/she be screened and enrolled in Healthy Kids Silver via NHHKC.

- 4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

The application process involves collecting information about current coverage and coverage in the past six months. Children currently covered will not be eligible for Healthy Kids Silver coverage. The state will review applications to determine whether applicants or employers of applicants have discontinued private or employer-sponsored dependent coverage in order to participate in the program. Children who had employer-sponsored coverage within the previous six months who lost coverage for reasons related to the availability of Healthy Kids Silver (e.g., no longer purchasing family coverage) will not be eligible. As noted in section 4.1.7, an application may be approved for good cause. Such reasons include: loss of employment, change of employment to an employer who does not provide dependent coverage, death of the employed parent, discontinuation of coverage to all employees (regardless of income) by the employer, insurer closes its operation in New Hampshire, an involuntary reduction in work hours that no longer allows the employee to enroll the employees dependent children under the employer's health plan, voluntary quit of employment and the quit occurred for any of the good cause reasons specified in New Hampshire Code of Administrative Rules He-W 910.09(c) (2)a-g, cases of domestic violence, a temporary insurance policy is ending, COBRA coverage if good cause existed when employer coverage was lost, loss of coverage beyond the control of custodial parent when non-custodial parent drops insurance, and loss of coverage when parent leaves work to be the primary caretaker for his/her children ages 5 and under (effective April 1, 2002).

- 4.4.4.1. Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.
Children, ages 0-19, in families with income at 0- 185% FPL, or newborns and infants ages 0-1 with income at greater than 185% to

300% of FPL are covered under Healthy Kids Gold (Medicaid or Medicaid expansion) and can have other insurance. Children ages 0-19, in families with income at 185%-300% FPL are on Healthy Kids Silver and can not have other health insurance. Therefore, the methods of monitoring substitution stated in section 4.4.4 apply.

- 4.4.4.2. Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

The methods of monitoring substitution stated in section 4.4.4 apply for these families

- 4.4.4.3. Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

The methods of monitoring substitution stated in section 4.4.4 apply for these families.

- 4.4.4.4. If the state provides coverage under a premium assistance program, describe:

N/A

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

- 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))

Cost sharing protection is in place to ensure enrollment of American Indians and Alaska Natives, as defined in 457.10. The following documents will be revised to disclose that members of federally recognized Indian Tribes and Alaska Natives are eligible for free coverage under Title XXI although the children may qualify for premium-based coverage:

- 1. The Children's Health Insurance Program Guide to Benefits – this is the primary information booklet that describes the programs and how to apply.*
- 2. Silver Eligibility Letter – Families who have applied for coverage through the DHHS District Office and are referred to NHHKC for enrollment.*
- 3. Silver Enrollment Letter – Families who have applied through the mail-in unit at NHHKC and have been deemed eligible for the premium-based Healthy Kids (Title XXI) program.*

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In order to process the free coverage enrollment, members of tribes will be asked to inform NHHKC of their tribe status by phone or mail. The contract between NHHKC and the State of New Hampshire will be amended to provide full reimbursement of the premium and co-payments for members of tribes to NHHKC (effective August 24, 2001).

Effective Date: *Phase 1: May 1998, Phase 2: Jan. 1999*

Approval Date: *September 1998*

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

Along with contracting with NHHKC to administer the Title XXI program, the state also contracts with NHHKC to market and perform outreach services for the state's Medicaid and SCHIP programs. An initial outreach plan was developed in partnership with NHHKC and other community health partners, to ensure that New Hampshire families are aware of the child health insurance coverage options available under Title XXI as well as under Title XIX. This plan was designed using the successful practices of NHHKC and capitalizes on the collaborative relationships already developed with schools and child care centers as well as expanding the existing network of social service agencies and advocacy groups beyond those that had traditionally worked with the state and NHHKC.

Outreach materials include a variety of brochures, posters, flyers, and enrollment package materials. Information covers the benefits offered, eligibility requirements, and how and where to apply. NHHKC employs 4 field coordinators in different areas of the state who maintain relationships with community partners and provide outreach support through training and promotional materials. The focus of this strategy is to work with organizations that directly serve families and children.

Outreach campaigns are conducted periodically to focus on boosting enrollment in specific target groups, such as developing materials to focus on infants. The outreach takes advantage of seasonal and geographic differences and events, such as the start of the school year. Historically, the most effective method of reaching families have been to distribute information through the schools.

Other elements of the outreach plan include:

- ◆ *Biannual blanket distribution of promotional postcards to all public and religious schools in the state;*
- ◆ *Distributing information through, child care centers, Head Start centers, WIC sites, community agencies and health care providers;*
- ◆ *Providing displays for these sites and appropriate commercial establishments;*
- ◆ *Use of retail bag stuffers;*
- ◆ *Using public speaking engagements, talk shows, public affairs programs, news releases, press conferences, and radio and TV PSAs as appropriate;*
- ◆ *Creating a special web site, Wired Wizard, with links to both Healthy Kids Corporation's website and the DHHS websites and where applications can be downloaded;*
- ◆ *Conducting direct mail campaigns to demographically selected lists that match profiles of uninsured families, building on the current Healthy Kids mailing lists of previous inquiries as well as other providers lists;*
- ◆ *Initial and refresher training of staff at all applications sites that provide one-on-one*

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assistance on such topics as how to effectively deal with inquiries and potential members to maximize the contact as an enrollment opportunity; accuracy and completeness of the application; and referrals to other services; and,

- ◆ *Developing an evaluation methodology based upon the concepts of continuous quality improvement to ensure the efficient and effective use of outreach resources.*

Effectiveness of outreach campaigns are tracked by referral sources on all families that inquire and apply. These statistics are compiled and analyzed through database queries. In addition, questions regarding outreach methods and messages are included in periodic surveys of enrollees, disenrollees and prospective enrollees. Over one-third of families indicate they learned about the program through their child's school.

Central to the state's goal of maximizing the enrollment of uninsured children are efforts to support speedy application and enrollment. Activities include:

- ◆ *Providing a toll-free telephone line to directly request brochures or other information packages and applications or to request assistance with completing an application;*
- ◆ *Developing one application for both Healthy Kids Silver and Healthy Kids Gold;*
- ◆ *Implementing a centralized mail-in enrollment center where applications can be mailed;*
- ◆ *Increasing the availability of on-site application assistance at community based organizations utilizing staff trained in the eligibility requirements of the various public health and state benefit programs.*

Special outreach efforts to minority and rural populations will be conducted through the upcoming Robert Wood Johnson Covering Kids and Families Grant, which will allow the state to pilot outreach, simplification and coordination of children's health care coverage programs in 2 local pilots locations, Manchester and the rural North.

Section 6.

Coverage Requirements for Children's Health Insurance (Section 2103)

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 7.

Effective Date: Phase 1: May 1998, Phase 2: Jan. 1999

Approval Date: September 1998

6.1. The state elects to provide the following forms of coverage to children:
(Check all that apply.) (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))
(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. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. **See instructions.**

- 6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania]
Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please 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 project
 - 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
 - 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 (Please 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))
In a short-term /general hospital, skilled nursing facility or physical rehabilitation facility.
- 6.2.2. Outpatient services (Section 2110(a)(2))
Facility charges and medical services, such as operating room, hospital, pharmacy and supplies, physician visits, laboratory and x-rays and surgery.
- 6.2.3. Physician services (Section 2110(a)(3))
Including primary care providers such as Advanced Registered Nurse Practitioners and Physician Assistants.
- 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))
Including all FDA approved oral contraceptives and Depo-Provera.
- 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))
Maximum of 15 days per year.
- 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))
Maximum of 20 visits per year.
- 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))
Eyeglasses, hearing aids, prosthetic devices and other DME as determined to be medically necessary and consistent with diagnosis.
- 6.2.13. Disposable medical supplies (Section 2110(a)(13))
Disposable medical supplies as medically necessary and consistent with

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diagnosis, are covered.

- 6.2.14. Home and community-based health care services (See instructions) (Section 2110(a)(14))
20 home health visits a year.
- 6.2.15. Nursing care services (See instructions) (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))
Diagnostic and preventive services including sealants, fillings, and simple extractions are covered 100% up to a maximum \$600 per child per year (effective January 1, 2001). No orthodontics are covered.
- 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
Inpatient detoxification for medically necessary stays. No limit on the number of times a member may be admitted for inpatient detoxification.
- 6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19))
Outpatient substance abuse visits wrapped into the 20 outpatient mental health benefit. Therefore a member will have a total of 20 outpatient visits for mental health and substance abuse counseling. Not 20 visits for each.
- 6.2.20. Case management services (Section 2110(a)(20))
- 6.2.21. Care coordination services (Section 2110(a)(21))
To be provided as part of the role of the Primary Care Provider.
- 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
24 visits for speech therapy; 24 visits for occupational therapy or 24 visits for physical therapy or a combination of occupational and physical therapies for each medical episode.
- 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))
Chiropractic services, allergy testing and treatment, cardiac rehabilitation services, infusion therapy, vision and hearing services, preventive health services such as diabetes management program, routine hearing exams, laboratory and x-ray tests, medical exams and childhood immunization for well children, prenatal care and vision care and early intervention services up to age 3, (\$3,200 annual, 9,600 lifetime maximum) are also covered (effective January 1, 2001).
- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. Medical transportation (Section 2110(a)(26))
Emergency transportation by ambulance.
- 6.2.27. Enabling services (such as transportation, translation, and outreach)

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- 6.2.28. services (See instructions) (Section 2110(a)(27))
Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))
Skilled nursing and rehabilitation facility services as deemed medically necessary and pre-authorized by the health plan.
- 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 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please 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)
N/A
- 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)

N/A

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

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))

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. (2102(a)(7)(A)) (42CFR 457.495(a)) *NHHKC and their insurance subcontractor are required to meet all standards for quality of care in the contract in order to contract with the state. The state reviewed and approved the subcontract agreement between NHHKC and the health plan prior to the enrollment of children into Healthy Kids Silver.*

Once the state has signed a contract with NHHKC, it will continuously monitor quality through various mechanisms, including: health plan contracting standards, reporting requirements, enrollee input, external reviews, and on-site reviews. The state will strive to establish a continuum across the Title XIX and Title XXI programs for quality e.g. contracting with the same External Quality Review Organization (EQRO), establishing priority areas for review and utilizing consistent measurement methodologies. The state will bear final responsibility for the quality improvement activities outlined in this application however, the quality improvement plan will be based upon a partnership with NHHKC and their contracted insurer.

The Phase 1 Healthy Kids Gold (Medicaid) program will be monitored via the established quality improvement program in the Medicaid Administration Services, and more specifically within the Medicaid Managed Care Unit. The established QIP includes the monitoring of quality and appropriateness of care and highlights well-baby and well childcare. It is based upon this pre-existing program that the Phase 2 quality improvement program will be designed.

For Phase 2, the contract with NHHKC will include specific standards for quality of care, including the provision of well-baby care, well-child care, and immunizations that will be carried out by the health plan as their subcontractor. The health plan will be required to arrange for immunizations, physical examinations, health education, dental examinations/treatments and comprehensive screens (and any needed interperiodic screens) in accordance with the schedules recommended by the most current Recommended Childhood Immunization Schedule, United States and the American Academy of Pediatrics. The health plan will be required to have enrollees up to date on screening and immunizations within 3 months of being enrolled.

Reporting will include a report on the plan's quality improvement plan (QIP), HEDIS reports on immunizations and well child care, and other pediatric preventive health measures as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, utilization reports, and periodic provider network reports. The state will require the subcontracted

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health plan to submit encounter data. The state recognizes that this information is crucial to the on-going monitoring and evaluation of the Healthy Kids program and will strive to develop a system that will receive, process and permit for detailed analysis, the scope of services provided to Healthy Kids enrollees. The state will work with NHHKC and the plan to develop the data elements, medium, format and time frames for submissions.

Other utilization information that involve health plan interventions and enrollee participation in activities such as complaints/grievance resolution, case coordination services, health risk screenings, disease management and health promotion programs will be reported and tracked.

NHHKC will be responsible for conducting enrollee satisfaction surveys. NHHKC may delegate this function to the health plan. However, the state will review and approve the survey tool for specific questions from the CAHPS instrument, sampling methodology, research design and final results. The state is also developing a provider satisfaction survey.

The functions of the external quality review organization are described in section 7.1.1. In addition, the state will conduct periodic focus groups as part of its on-going community involvement process and maintains the option of conducting annual on-site evaluations at the health plan to assess compliance with contract requirements (such as utilization management decisions), and to establish, with the health plan, quality improvement projects and performance goals.

On-site reviews at the network provider level will be conducted based on provider profile information generated by encounter data for certain quality/utilization indicators, frequency of PCP changes and patterns of complaint and grievance data. As part of an on-site visit, enrollee medical records will be reviewed for the following:

- ◆ *evidence of the provision of access to care within contract standards,*
- ◆ *review of specific areas of care/treatment identified as outliers (i.e. increased emergency department visits or asthma hospitalizations),*
- ◆ *medical decision making (management of a specific diagnosis) and*
- ◆ *compliance with standard elements of documentation (i.e. comprehensive health risk screening).*

Review findings will be summarized, noting variances with criteria, standards and performance. Written reports with summary data, issues and recommendations will be submitted to NHHKC, the health plan, the Commissioner's Consumer Policy Advisory Board and the Commissioner's Managed Care Advisory Committee.

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

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The state will contract for an external quality review of the health plan. Such review shall include, but not be limited to, an evaluation of access to care, quality of care studies, medical record standards, and individual case review and appropriateness of care. All activities carried out by the EQRO will be prior approved by the state in order to assure appropriate monitoring and to assure consistency in quality improvement activities across programs.

7.1.2.

Performance measurement

The state will require the health plan to submit HEDIS reports on immunizations, well child visits and other pediatric preventive health measures. The state will develop specific performance targets or required degrees of improvement on particular measures in conjunction with NHHKC and the health plan. The plan and the state will identify two (2) HEDIS measures under the Effectiveness of Care, Use of Services and/or Access domains where improvement will be targeted. Within specific time frames, the plan will achieve a benchmark level of performance defined and agreed to in advance or will achieve a reduction of at least ten percent (10%) in the number of enrollees who do not achieve the outcome defined by the indicator (or if applicable, in the number of instances in which the desired outcome is not achieved).

The state will adopt where possible the guidelines issued by CMS under the Quality Improvement System for Managed Care (QISMC), as finalized, in its quality oversight system.

7.1.3.

Information strategies

The state, NHHKC, and the health plan will be required to educate enrollees about their benefits under Healthy Kids Silver and Healthy Kids Gold as well as their rights and responsibilities. The plan will also educate enrollees about the importance of preventive services, health promotion activities, care coordination services, disease management programs, and visiting their primary care provider instead of an emergency room.

7.1.4.

Quality improvement strategies

The contract with NHHKC will include specific standards for quality of care including access to care and appointment availability, and the health plan will have to meet those standards in order to contract with NHHKC and the state. These standards will be monitored by the state and NHHKC through reporting requirements, on-site reviews, external reviews and enrollee input through complaint data and satisfaction surveys.

In particular, the plan will be required to establish an internal quality improvement plan (QIP), which will be in writing and available to the public. The written description shall include detailed goals and annually developed

objectives; address the quality of clinical care and non-clinical aspects of services for the range of care provided by the plan; specify quality of care studies and related activities; provide for continuous performance of activities, including tracking of issues over time; and provide for review and feedback by physicians and other health professionals. By the end of the first contract year, the plan will be required to initiate two (2) clinical focused projects aimed at improving care for enrollees. Clinical focus areas applicable to this target population include topics related to:

- ◆ *lead toxicity screening and treatment,*
- ◆ *chronic pediatric asthma,*
- ◆ *attention deficit disorder,*
- ◆ *adolescent counseling on smoking and substance abuse,*
- ◆ *well-child care,*
- ◆ *behavioral health screening and treatment and*
- ◆ *perinatal services.*

The state, NHHKC and the health plan will work collaboratively to select the clinical areas to be studied and define the improvement strategy.

An annual report on the QIP will be required. This report will be made in the form of a presentation to the state and its community advisors. In addition, the report will be made available as a formal written report that will be made available to the public as hard copy and on the DHHS website.

For Healthy Kids Silver enrollees that become pregnant while eligible, comprehensive perinatal services shall be available and accessed through the contracted health plan. The plan's purchasing specifications must describe and demonstrate a comprehensive, proactive perinatal program with adherence to care guidelines as recommended by the American College of Obstetrics and Gynecology. HEDIS perinatal and birth outcome indicators will be utilized to measure and assess performance. Depending upon the results and trends, the health plan's QIP shall be expected to develop further interventions and strategies to increase participation and positive outcomes.

7.2. Describe the methods used, including monitoring, to assure: **(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))**

The state requires the Healthy Kids Silver health plan to provide access to preventive care such as, well-child care, well-adolescent care and childhood and adolescent immunizations. No office visit co-payments are required for routine childhood examinations and immunizations. The state requires the health plan to include sufficient numbers of appropriately trained and certified staff to provide this access to care. The state and NHHKC monitor access requirements through reporting and

member satisfaction surveys. Infants covered under Title XXI receive well-baby care under Healthy Kids Gold as part of the Medicaid expansion. The state monitors access issues for Healthy Kids Gold.

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))

The state requires the health plan to include sufficient numbers of appropriately trained and certified clinicians of pediatric care, including primary, medical subspecialty and surgical specialty physicians, as well as providers of necessary related services such as, dental and mental health services. The state monitors network capacity through quarterly provider network reports and will suspend enrollment if capacity is exceeded.

The health plan is required to ensure that their provider networks provide access to primary care providers (PCPs) within 20 miles/45 minutes and access to emergency services on a 24-hour, seven-day-a-week basis. Emergency care shall be provided immediately, urgent care within 24 hours, non-urgent, symptomatic PCP appointments shall be available within 48 hours from the enrollee's request to be seen and non-symptomatic, routine/preventive care within 30 calendar days. An emergency medical condition will be defined as a condition such that a prudent lay person, acting reasonably, would have believed that emergency medical treatment is needed. The state and NHHKC monitor access requirements through reporting and member satisfaction surveys.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, 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))

The health plan is required to treat enrollees with chronic, or serious medical conditions, and provide access and adequate number of visits to specialists experienced in treating the specific medical condition. Enrollees will have access to out-of-network providers when the network is not adequate for the enrollee's medical condition. The state and NHHKC will monitor access requirements through reporting and member satisfaction surveys.

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))

Most health services do not require prior authorization unless a referral is made to an out of network provider. Decisions related to prior authorization of health services are in accordance with the New Hampshire Department of Insurance's regulations.

Section 8. Cost Sharing and Payment (Section 2103(e))

- 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)

- 8.1.1. YES
8.1.2. 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 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:

*There are no premiums for Healthy Kids Gold.
Under Healthy Kids Silver, families whose income is greater than 185% and equal to or less than 250% of FPL pay a \$25 per child per month premium, and there is a \$100 cap on monthly premiums for these families with multiple children. Families whose income is greater than 250% and equal to or less than 300% of FPL pay a \$45 per child per month premium, and there is a \$135 cap on monthly premiums for these families with multiple children.*

8.2.2. Deductibles:

There are no deductibles for Healthy Kids Gold or Healthy Kids Silver.

8.2.3. Coinsurance or co-payments:

*There is no coinsurance for Healthy Kids Gold or Silver.
There are no co-payments for Healthy Kids Gold.
For Healthy Kids Silver, there is a \$10 co-pay for provider office visits, \$5 for generic prescription drugs, and \$10 for brand name drugs. There is also a \$50 co-payment for emergency care, unless the patient is admitted to the hospital. There are no co-payments for preventive health and/or well child visits, dental check-ups, dental x-rays, cleanings and fluoride treatments.*

8.2.4 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)(B)) (42CFR 457.505(b))
Both the state and NHHKC provide information on the cost sharing requirements to enrollees

as well as to the provider community. Information about premiums and co-pays are included in all outreach/education material including brochures, flyers, posters, the Children's Health Insurance Guide to Benefits and on the website. It is also included in the enrollment materials that the family receives. Families that have enrolled are sent enrollment forms that give them the amount of what that 5% cap out of pocket expense will be.

- 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)**
The state plan follows this requirement.
- 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)**
The state plan follows this requirement.
- 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))**
The state plan follows this requirement.
- 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))**
The State contracts with NHHK to provide for the administration of the cost-sharing provisions of the Title XXI plan. As part of its role, NHHK educates families about the cost sharing rules and requirements including premiums and co-payments. The education includes; how much money 5% of the family's income, translated into terms of dollars and cents, what period of time the monitoring period covers, and that the responsibility for monitoring out of pocket expenses will be shared by the family and NHHK. The education will instruct families in tracking their out of pocket expenses on a monthly basis (the emphasis will be on tracking and documenting medical/dental office and pharmacy co-payments) and to contact NHHK immediately (via mail or the statewide toll free number) should their out of pocket expenses equal or exceed the previously determined amount of money or if the family income should suddenly decrease. NHHK also monitors medical and dental co-payments on a quarterly basis via a cost sharing report generated by health and dental plans. Premium cost-sharing is monitored directly by NHHK via their accounting system.

Families who exceed the 5% cap will be formally notified by NHHK in writing and all cost sharing will cease for the remainder of the current 12 month eligibility period. The letter will include the specific date that the cost-sharing exemption expires (it coincides with the eligibility re-determination date). The family utilizes the NHHK formal notification as proof of exemption from cost-sharing, to be presented to providers as needed. The State and NHHK will emphasize and re-emphasize cost-sharing rules and regulations in its provider education

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and communications. Out of pocket expenses that exceed the 5% cap will be reimbursed to the family after review of all cost sharing documentation for the family, NHHKC and medical/dental plans. At the end of the first 12 months of eligibility, eligibility will be re-determined; the 5% cap will be recalculated for the family and the monitoring cycle will begin anew.

- 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)

Cost sharing protection is in place to ensure enrollment of American Indians and Alaska Natives, as defined in 457.10. The following documents will be revised to disclose that members of federally recognized Indian Tribes and Alaska Natives are eligible for free coverage under Title XXI although the children may qualify for premium-based coverage:

1. *The Children's Health Insurance Program Guide to Benefits – this is the primary information booklet that describes the programs and how to apply.*
2. *Silver Eligibility Letter – Families who have applied for coverage through the local DHHS District Office and are referred to NHHKC for enrollment.*
3. *Silver Enrollment Letter – Families who have applied through the mail-in unit at NHHKC and have been deemed eligible for the premium-based Healthy Kids Silver program.*

In order to process the free coverage enrollment, members of tribes will be asked to inform NHHKC of their tribe status by phone or mail. The contract between NHHKC and the State of New Hampshire will be amended to provide full reimbursement of the premium and co-payments for members of tribes to NHHKC (effective August 24, 2001).

- 8.7 Please 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 Please 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, co-payments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

There are no premiums, co-payments, coinsurance, or deductibles for Healthy Kids Gold.

There are no coinsurance or deductible fees for Healthy Kids Silver. However, there are co-payments and premiums. Providers are responsible for collecting the co-payments at the

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time of service. Premiums for Healthy Kids Silver are collected by NHHKC under contract with the Department of Health and Human Services as a third party administrator for Healthy Kids Silver.

In accordance with federal regulations, if payment has not been collected, eligibility may be terminated after sixty (60) days due to the non-payment of premiums. (As noted in section 3.1, pregnant teens do not have their eligibility terminated for failure to pay premiums until after the postpartum period.)

Families have until the last day of the current month to pay the next month's premium. The state has established a process that give enrollees reasonable notice and opportunity to pay past due premiums. At a minimum, 3 points of contact are made to the family. The process is as follows:

- *NHHKC will send a notice if a premium payment is 15 days past due.*
- *When the account is then 25 to 30 past due, a call is made to the enrollee.*
- *After a second payment has been missed, a letter of "intent to terminate" is sent to the family.*
- *The family will receive a final phone call when the account is 38 -40 days past due. They will have until the 45th day to pay premium. On the 46th day, if payment still has not been made they are sent notice of termination.*

Termination for non-payment is effective the beginning of the next month. The child or children will still receive health insurance coverage during the 2 months that payment is past due.

If the family has been terminated for non-payment of premiums, they are "locked out" of the program for 3 months by the state's New HEIGHTS eligibility system.

NHHKC supports a premium rescue fund through which charitable dollars are used to help families overcome a temporary loss of income or unexpected financial crisis.



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))

As noted in section 4.3, enrollees are required to notify NHHKC of any

change in circumstance that could affect continued eligibility for coverage. If enrollee notifies NHHKC prior to disenrollment for non-payment of premiums and the child is no longer eligible for Healthy Kids Silver, he/she will be disenrolled. If he/she is eligible for Medicaid, he/she will be enrolled in Healthy Kids Gold (Medicaid). The family also has the opportunity to show that their income has declined enough to make them eligible for the lower premium category of Healthy Kids Silver, which will then facilitate the enrollment into that premium level.

- 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))

As noted in section 4.3, enrollees are required to notify NHHKC of any change in circumstance that could affect continued eligibility for coverage. If enrollee notifies NHHKC prior to disenrollment for non-payment of premium, and the child is no longer eligible for Healthy Kids Silver, he/she will be disenrolled. If he/she is eligible for Medicaid, he/she will be enrolled in Healthy Kids Gold (Medicaid). There is no cost-sharing for Healthy Kids Gold. The family also has the opportunity to show that their income has declined enough to make them eligible for the lower premium category of Healthy Kids Silver, which will then facilitate the enrollment into that premium level.

- The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

Individuals have a right to request an Administrative Appeals Hearing if they are not satisfied with any decision made by the Department of Health and Human Services or NHHKC. Hearings can be requested verbally or in writing by contacting a DHHS district office, NHHKC or the Office of Administrative Appeals. This information is on the Healthy Kids application.

- 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, copays, 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

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- 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 (Section 2107)

- 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))
- 1) *Increase the number of low-income children in New Hampshire who are insured;*
 - 2) *Improve the health status of children in New Hampshire with a focus on preventive and primary care;*
 - 3) *Maximize participation in Title XXI through outreach, a single point of entry, a simplified application process, and continuous eligibility;*
 - 4) *Maximize coordination with Medicaid to ensure coverage of children previously eligible but not enrolled in Medicaid.*

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

1) *Increase the number of low-income children in New Hampshire who are insured.*

Decrease the proportion of children 1-19 \leq 300% of FPL who are uninsured by 25% in the first year, 35% in the second year, 45% in the third year, and 50% in the fourth year.

2) *Improve the health status of children in New Hampshire with a focus on preventive and primary care.*

As noted in section 7.1.2, the state will require the health plan to submit HEDIS reports on immunizations, well child visits and other pediatric preventive health measures. The state will develop specific performance targets or required degrees of improvement on particular measures in conjunction with NHHKC and the health plan. The plan and the state will identify two (2) HEDIS measures under the Effectiveness of Care, Use of Services and/or Access domains where improvement will be targeted. Within specific time frames, the plan will achieve a benchmark level of performance defined and agreed to in advance or will achieve a reduction of at least ten percent (10%) in the number of enrollees who do not achieve the outcome defined by the indicator (or if applicable, in the number of instances in which the desired outcome is not achieved). At a minimum the state will expect to address the following goals based on the strategic objectives in section 9.1.

Match or exceed the current statewide average percentage of children under two who receive the basic immunization series.

Match or exceed the current statewide average percentage of 13 year olds who receive the basic immunization series.

Match or exceed the current statewide average percentage of 3,4,5, and 6 year olds who have at least one well-child visit during the year.

Match or exceed the current statewide average percentage of 12 through 18 year olds who have at least one well-child visit during the year.

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3) *Maximize enrollment in Healthy Kids Silver and Healthy Kids Gold through outreach, a single point of entry, a simplified application process, and continuous eligibility*

Increase the number of locations where individuals can get applications and receive assistance in completing applications.

Increase the number of entities participating in the outreach program.

Increase the percentage of applications requested that are completed.

Decrease the amount of follow-up required to complete applications.

Ensure that at least 75% of consumers are satisfied with the application process.

4) *Maximize coordination with Medicaid*

Increase enrollment in Healthy Kids Gold (Medicaid) by ten percent (10%) in the first year of operations.

Establish a seamless program with integrated staff and administration.

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))

1) *Increase the number of low-income children in New Hampshire who are insured. This will be measured by data from the NH Department of Health and Human Service's Household Insurance Survey conducted under the direction of the Office of Planning and Research.*

2) *Improve the health status of children in New Hampshire with a focus on preventive and primary care - The health plan(s) will be required to submit data on immunizations and well-child visits. The state will use these data to make comparisons to the current percentages.*

3) *Maximize participation in Healthy Kids Silver and Healthy Kids Gold through outreach, a single point of entry, and a simplified application process. Performance goals will be measured by collecting information on the number of locations that provide applications and assistance and that are involved in outreach and comparing that to current participation. The state will also conduct surveys regarding completed applications, follow-up, and satisfaction with the application process.*

4) *Maximize coordination with Healthy Kids Gold (Medicaid) - The state will collect information on Medicaid enrollment through its eligibility system and compare it to current enrollment.*

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

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- 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 child care
 - 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, please list:
 - 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)

DHHS 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.

- 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)

DHHS will perform the annual assessments and evaluations required under sections 10.1 and 10.2. The annual report will assess the operation of the Title XXI plan, including the progress made in reducing the number of uninsured children. This will be measured by data from the NH Department of Health and Human Service's Household Insurance Survey conducted under the direction of Office of Planning and Research.

- 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)

DHHS assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit.

- 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))

DHHS assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

- 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))

A multidisciplinary group comprised of Department staff and representatives from the Governor's Office and NHHKC worked to develop and review the initial conceptual model. The Department met with the NHHKC Board of Directors on March 2, 1998, to review the proposed model and to solicit input into the plan. The Board membership includes representatives from the Department of Education, Department of Insurance, State Legislators, New Hampshire School Boards Association, New Hampshire Pediatric Society, New Hampshire School Nurses Association, New Hampshire Children's Alliance, New Hampshire Child Care Association, and the New Hampshire Hospital Association. Follow up meetings were held with the Board of Directors. The Department also met with representatives from Blue Cross Blue Shield of New Hampshire.

A series of public meetings were also held throughout the state. Each session included an overview of the Title XXI legislation and application requirements; a review of proposed conceptual plan; and a review of the proposed benefits package. In addition to providing time for commentary on the plan, time was spent on developing a long-term plan to ensure ongoing public involvement. From each session a list of questions and answers as well as comments was generated and documented. Department staff followed up unanswered questions.

The public meetings included:

<i>March 12, 1998</i>	<i>The Commissioner's Managed Care Advisory Group and NH Child Action Team</i>
<i>March 18, 1998</i>	<i>Community Mental Health Centers Executive Directors</i>
<i>March 19, 1998</i>	<i>The Consumer Policy Advisory Board</i>
<i>March 24, 1998</i>	<i>A formal Public Hearing was held on the NH CHIP Plan</i>
<i>March 27, 1998</i>	<i>The Welfare Reform Advisory Group</i>
<i>April 1, 1998</i>	<i>The Medicaid Medical Care Advisory Committee</i>
<i>April 10, 1998</i>	<i>Child Health Coordinators of the Title V-funded Well Child Clinics and Primary Care agencies</i>
<i>April 14, 1998</i>	<i>Headstart Health and Nutrition Coordinators</i>
<i>April 14, 1998</i>	<i>RWJF Outreach Grant Participants</i>
<i>April 15, 1998</i>	<i>Health Planning District Council Meeting in Manchester</i>
<i>April 16, 1998</i>	<i>Health Planning District Council Meeting in Plymouth</i>
<i>April 20, 1998</i>	<i>A formal Public Hearing on rule changes for the NH CHIP Plan</i>

Future presentations already scheduled include:

<i>May 11, 1998</i>	<i>NH DHHS Primary Care Steering Committee</i>
<i>May 15, 1998</i>	<i>Commissioner's Child Care Advisory Committee</i>

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May 21, 1998

NH Welfare Directors/NH Municipal Association

In addition to the public meetings noted above, the state created a site on the DHHS web page (www.state.nh.us/dhhs/deptlinks.htm). The web site includes information on the proposed plan and as each section of this application was drafted, it was added to the web page. A copy of the final working draft of the application was made directly available to a variety of advocacy groups and community leaders.

DHHS continues to include the public in ongoing efforts involving SCHIP. These efforts include:

- ◆ *The SCHIP workgroup that originally met to assist the Department in working through a variety of operational issues such as eligibility, enrollment, benefits, cost-sharing and outreach continues to meet to provide input and public process to program changes.*
- ◆ *DHHS hosted a SCHIP Summit with DHHS and community partners in November 2000, to discuss the progress of the SCHIP program and to identify issues and barriers to enrollment and retention. From the summit, 6 workgroups were formed; presumptive eligibility, good cause waivers, application, documentation, continuous eligibility, and letters and notices. Workgroups generated recommendations for policy and practice that would enhance enrollment and retention of eligible children in the Healthy Kids programs.*
- ◆ *Four regional meetings were held in the fall of 2001 to review workgroup recommendation and further solicit input from both internal and external stakeholders in Healthy Kids programs. These stakeholders included providers (hospitals, CHCs and private offices), past and current families enrolled in Healthy Kids, human service agencies as well as outreach and advocacy groups.*
- ◆ *A public hearing was held on October 26th, 2001 by the Department on "Proposed Changes to State's Children's Health Insurance Program State Plan", in order to receive written and oral comments. These changes included reduced verification, improving the presumptive eligibility process, a further simplified Healthy Kids application, and additional good cause waivers of prior insurance. The changes requiring a state plan amendment to CMS are included in this plan. DHHS amended its administrative rules to reflect these changes.*

- 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. (Section 2107(c)) (42CFR 457.120(c))
There are no organized tribes or tribal organizations in New Hampshire, however public process for amendments relating to 42 CFR 457.125 included four regional meetings to solicit input from both internal and external stakeholders in the Healthy Kids program. These stakeholders included providers (hospitals, CHCs and private

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offices), past and current families enrolled in Healthy Kids, human service agencies as well as outreach and advocacy groups. A public hearing was held on October 26th, 2001 by the Department on "Proposed Changes to State's Children's Health Insurance Program State Plan" in order to receive written and oral comments.

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

Public process for amendments relating to eligibility or benefits included four regional meetings to solicit input from both internal and external stakeholders in the Healthy Kids program. These stakeholders included providers (hospitals, CHCs and private offices), past and current families enrolled in Healthy Kids, human service agencies as well as outreach and advocacy groups. A public hearing was held on October 26th, 2001 by the Department on "Proposed Changes to State's Children's Health Insurance Program State Plan" in order to receive written and oral comments.

Changes made to co-payments and premiums on January 1, 2003, were published in the Rulemaking Register on September 13, 2002. A public hearing was held on October 4, 2002 for the public comment process. A meeting with community partners was held, and all families received notice of this change prior to its implementation. Costs and premiums do not exceed 5% of the total family income.

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9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. 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 sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

FFY 2003

	Federal Fiscal Year Costs
Enhanced FMAP rate	
Benefit Costs	
Insurance payments	\$5,129,580
Managed care	
<i>115.17x51705 +133.14x18885 (per mem. x total members)</i>	
Fee for Service	\$65,754
Total Benefit Costs	\$5,195,334
(Offsetting beneficiary cost sharing payments) <i>cost sharing included above</i>	
Net Benefit Costs*	
Administration Costs	
Personnel	
General administration	
Contractors/Brokers (e.g., enrollment contractors)	\$812,295
Claims Processing	
Outreach/marketing costs	
Other	
Total Administration Costs	\$812,295
10% Administrative Cost Ceiling	\$577,259
Federal Share (multiplied by enh-FMAP rate)	\$3,752,185
State Share**	\$2,020,408
TOTAL PROGRAM COSTS	\$8,772,593

Note: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

*Benefit costs are already net of cost sharing payment

**The source of state funding is from the state's general fund and a \$224,000 donation from the

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Healthy New Hampshire Foundation.

Section 10. Annual Reports and Evaluations (Section 2108)

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 uncovered 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.

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.**

Eligibility and Enrollment Matters

- 12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR . 457.1120.

As noted in section 8.7.1, individuals have a right to request an Administrative Appeals Hearing if they are not satisfied with any decision made by the Department of Health and Human Services or NHHKC. Hearings can be requested verbally or in writing by contacting a local district office, NHHKC or the Office of Administrative Appeals. These Administrative Appeals Hearings are the same as the Medicaid process and include both Healthy Kids Silver and all Healthy Kids Gold. This information is on the Healthy Kids application.

Health Services Matters

- 12.2 Please describe the review process for **health services matters** that complies with 42 CFR . 457.1120.

If the child is enrolled in Healthy Kids Gold, the process to review health services matter is through the state's Medicaid fair hearing process. If the child is enrolled in Healthy Kids Gold Managed Care or Healthy Kids Silver, individuals have the right to appeal any decision made that the health insurer makes about coverage, benefits, or failure to provide coverage or benefits through the managed care internal appeal process. In addition to the internal appeal procedure, individuals have the right to an external review process to appeal decisions regarding denial, delay, reduction, suspension or termination of health care services and the failure to provide payment for health services in a timely manner through an Administrative Appeals Hearing. If an individual is not satisfied with any decision made by the health insurer, hearings can be requested verbally or in writing by contacting the department of Health and Human Services, a local district office, the health insurer, NHHKC, or the Office of Administrative Appeals. These Administrative Appeals Hearings are the same as the Medicaid process and includes both Healthy Kids Silver and Healthy Kids Gold Managed Care. This information is on the Healthy Kids application.

Premium Assistance Programs

- 12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR . 457.1120, please 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.

N/A