



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE COMMISSIONER

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603-271-4688

Terry L. Morton
Commissioner

July 27, 1998

Kathleen G. Sgambati
Deputy Commissioner

Ms. Gail Sausser
Project Officer
Health Care Financing Administration
Division of Integrated Health Systems
7500 Security Boulevard, S2-01-16
Baltimore, Maryland 21244-1850

Dear Ms. Sausser:

Thank you for the opportunity to provide additional information regarding New Hampshire's Title XXI Children's Health Insurance Plan. Enclosed are the answers to your questions which provide supplemental information regarding our proposal. We have included substitute pages as requested and have cited these pages within the narrative.

Our public process and work with stakeholders has continued even after the May 30th submission of the CHIP plan. This feedback and ongoing program development activities have led us to modify portions of the State plan. The State is requesting review of these changes. The modifications and the rationale for the modifications include:

- Creating a two tier premium to replace the one tier **\$15** per child per month premium.
The overwhelming public response to the proposed **\$15** per child per month premium for children in Phase 2 of the CHIP plan included the recommendation to create a *two* tier premium payment. Families whose income is greater than **185% FPL** and equal or less than **250% FPL** would pay a \$20 per child per month premium. Families whose income is greater than **250% FPL** and equal or less than 300% FPL would pay a **\$40** per child per month premium. In addition to the public input, a legislative test of the **\$15** per child per month premium failed, thus the State has chosen to create the *two* tier premium system.
- Creating a family cap of **\$100** on premium cost-sharing for families with multiple children.
To assure participation in the CHIP program by NH families while maintaining an adequate state contribution, the State wants to implement a **\$100** cap on monthly premiums. The State is creating an administrative infrastructure that will be able to monitor and report out cost-sharing by family and thus operate the program within the federal rules and regulations.

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- Changing the co-pay on prescriptive drugs from \$5 per prescription to \$5 for generic drugs and \$10 for brand name drugs.
This modification is being implemented to impact cost control. A recent financial analysis of the state's pharmaceutical costs indicates these costs are surpassing all others in the Medicaid program. In order for the state to provide this benefit, a change in the CHIP program is necessary to control drug utilization and subsequently, drug costs.
- Implementing a 3 month lock out for reapplication should a family fail to participate in the cost-sharing provisions. This would only apply to those families who did not meet the good cause provisions and after a 60 day grace period.
This change is aimed at reducing administrative costs associated with the enrollment and disenrollment of families and more importantly to empower families to take responsibility for their health insurance. It is consistent with the philosophy of other federal programs such as the Welfare Reform legislation and was one of the primary recommendations from consumers and advocates.
- Changing the name of the CHIP program from Kids Care and Kids Care PLUS.
The State received a great deal of feedback on its chosen name for the Title XIX and Title XXI programs. Concerns regarding the use and interpretation of the word "PLUS" were voiced as well as concern over not capitalizing on the established market presence of the Healthy Kids Corporation. The State convened its Outreach Workgroup and charged the members with recommending new names for the programs. The recommendation includes renaming the Title XIX Medicaid children's programs (including the Phase 1 CHIP Medicaid expansion) Healthy Kids -Gold and naming the Title XXI Phase 2 program Healthy Kids - Silver.

Please let us know as soon as possible if you require additional information to approve our plan. We appreciate the work you and your colleagues have done on this exciting program. We are committed to providing this coverage as quickly as possible and we appreciate your efforts to make this a reality.

If you have any additional questions please contact Kathleen Sgambati, Deputy Commissioner, New Hampshire Department of Health and Human Services at (603) 271-4600.

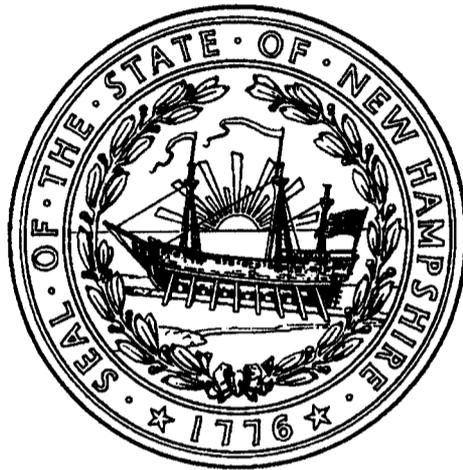
Sincerely,

Kathleen G. Sgambati

Enclosure
cc Mr. Ron Preston, HCFA Region 1

State of New Hampshire

Title XXI Children's Health Insurance Plan



**State Responses to Questions from the
Health Care Financing Administration**

July 1998

**NEW HAMPSHIRE TITLE XXI PLAN
REQUEST FOR ADDITIONAL INFORMATION RESPONSE**

Section 1. General Description and Purpose of the State Title XXI Plan

1. Please provide an assurance that the Title XXI State plan will be conducted in compliance with all civil rights requirements. This assurance is necessary for all programs involving continuing Federal financial assistance.

The State of New Hampshire assures that the Title XXI State Plan will be conducted in compliance with all civil rights requirements. Please see Section 1.3, page 6 of this document, and substitute this page for those previously submitted. All modifications are noted in boldprint.

2. Section 1.3. Please clarify that the Phase II program will cover children from ages 1 through 18, not 19 as written.

Phase 2 of New Hampshire's CHIP plan will cover children from 1 through 18 years of age. Please see Section I found on page 6 of this document and substitute this page for those previously submitted. All modifications are noted in boldprint.

Section 2. General Background and Description of State Approach to Child Health Coverage

3. Section 2.1. Is the Health Kids Corporation a health insurance company licensed by the State?

The Healthy Kids Corporation is not a health insurance company licensed by the State. The Corporation is a private, non-profit organization that was created by the State Legislature in 1993 to address the growing problem of uninsured children. The Corporation functions as a third party administrator providing the necessary infrastructure that allows families to purchase health insurance coverage for their uninsured children. The Corporation contracts with a health plan (Blue Cross Blue Shield of New Hampshire) which is licensed by the state.

Section 3. General Contents of State Child Health Plan

4. Section 3.1. Can the State please clarify why the six month period of guaranteed eligibility applies only to infants enrolled in the voluntary managed care program and not to those in the fee for service environment?

The State has opted to continue its current policy of guaranteeing 6 months eligibility for Title XXI eligible infants who enroll in a managed care health plan. This policy is consistent with the State's Medicaid state plan.

Section 4. Eligibility Standards and Methodology

5. Section 4. Please submit a change page which checks off all the appropriate boxes in Section 4.

Please see "Section 4: Eligibility Standards and Methodology, page 10 of this document, and substitute these pages for those previously submitted. The requested correction has been completed. All modifications are in bold print.

6. Section 4.1.7. The first sentence in this section implies that children covered by Kids Care Plus (Medicaid) are not eligible if they have other insurance. Our understanding is that children between 0-1 will be covered under the Medicaid coverage group at Section 1902(a)(10)(ii)(IX) using Section 1902(r)(2) disregard and not as "optional targeted low income children" as defined in 1905(u)(2)(C), thus they would be eligible regardless of whether they have other insurance. If this is correct, please clarify the language in this sentence. With regard to the remainder of section 4.1.7, please confirm that it applies to the Kids Care (Phase 2) program which is separate from Medicaid coverage.

Please see "Section 4: Eligibility Standards and Methodology", page 10 ~~of~~ this document, and substitute these pages ~~for~~ those previously submitted. The requested confirmation has been completed. All modifications are in boldprint.

7. Section 4.1.8. What is the duration of eligibility for children not enrolled in managed care?

Please see "Section 4: Eligibility Standards and Methodology", page 10 ~~of~~ this document and substitute these pages ~~for~~ those previously submitted. The question has been answered on page 10 and is noted in boldprint.

8. Section 4.3. Please review your plan to indicate that the State will not require applicants to Kids Care to provide their Social Security number. Section 1137's requirements for furnishing a Social Security number only apply to applicants for and recipients of Medicaid. It does not apply to the parents of Medicaid applicants, nor does it apply to a State run Child Health Insurance Program which is separate from the State's Medicaid program. The Privacy Act, 7 of Pub. L No 93-579, 88 Stat. 1896, makes it unlawful for a State to deny benefits to an individual based upon that individual's failure to disclose the Social Security number unless the disclosure is required by federal law or was part of a federal, state, or local system of records in operation before January 1, 1975. Since the new CHIP program does not require furnishing Social Security numbers and the Medicaid program only requires it for applicants and recipients, states may only seek these account numbers from others on a voluntary basis. On joint applications, for children enrolling in a separate State insurance program and members of the household not receiving benefits, the Social Security number should be indicated as being optional.

Please see "Section 4: Eligibility Standards and Methodology", page 10 ~~of~~ this document, and substitute these pages ~~for~~ those previously submitted. The requested correction has been completed on page 11. All modifications are in boldprint.

9. Section 4.3. Please clarify what happens if children are found not eligible for Medicaid simply because of procedural reasons-does that then make them eligible for Title XXI?

Please see "Section 4: Eligibility Standards and Methodology", page 10 of this document and substitute these pages ~~for~~ those previously submitted. The requested clarification has been completed on page 11. All modifications are in boldprint.

Section 5. Outreach and Coordination

No questions submitted.

Section 6. Coverage Requirements for Children’s Health Insurance

10. Section 6.1.2. Mental health benefits were not listed in the actuarial chart attached to the Mercer Group study. Please verify that mental health benefits also meet the requirements of coverage actuarial equivalency under Section 2103(a)(2)(C).

Benefit	Healthy Kids cost sharing and Limits	FEBHP cost sharing and lim
Inpatient Hospital	\$0, limit of 15 days per year	\$150 per day, 100 days per y
Outpatient Hospital	\$5 copayment, 20 visits per	\$200 deductible, 60%PPA, 2 visits per year

11. Section 6.1.2. Please explain the inconsistencies contained in the Mercer letter and chart as follows:

* The Mercer letter indicates that benefits under the State plan are 15% higher than the base plan, yet the chart lists the value as 18% higher.

The certification of benefits being 15% higher was used in order to be conservative for the comparison. Mercer recognizes that the future utilization of the HKC program is unknown, and to evaluate the benefit values to the nearest percent is unlikely. Mercer’s policy is to give a range when pricing a new benefit; for this comparison Mercer took the low end of the range.

*The chart includes vision as an equivalent benefit for comparison, but the FEBHP does not include vision benefits. Will the State please clarify how vision is equivalent on a categorical evaluation?

The vision benefit is not included in the FEHBP but is included in the Healthy Kids Corp. program. Mercer addressed the issue as follows:

- *The base data used for comparison included vision, which was appropriate for the Healthy Kids Corp. plan, but not appropriate for the FEHBP.*
- o *Vision was combined with other services in Mercer’s comparison data, so Mercer could not simply eliminate one line from the FEHBP cost.*
- o *To effectively eliminate vision from the FEHBP, Mercer assumed that the vision benefit had 100% cost sharing under the FEHBP. In the financial proforma, Mercer had to show a higher cost sharing in the appropriate line, since this line included other services as well as vision.*
- o *Mercer estimated that the average cost of all services in the line including vision was \$40. To eliminate vision’s share of this average, Mercer placed the cost sharing much higher under the FEHBP than under the Healthy Kids Corp. plan. The cost sharing for the Healthy Kids Corp. plan was only \$5, and for the FEHBP it was \$20.*

Section 7. Quality and Appropriateness of Care

No questions submitted.

Section 8. Cost Sharing and Payment

12. Section 8.4 and 8.6. Can the State please reformat its document to check off the boxes necessary for these sections, and check all those that apply.

Please see "Section 8: Cost Sharing and Payment", page 15 of this document. The requested correction has been completed. All modifications are in bold print.

13. Section 2103(e). The total annual aggregate cost-sharing for all target low-income children in a family may not exceed 5% of total family income for the year. As indicated in the State Health Official letter of February 13, States must inform families of these limits and provide a mechanism for families to stop paying once cost-sharing limits have been reached. Please describe how the State will coordinate its medical and dental programs so that it will know when a family has reached their 5% cap.

The Healthy Kids Corporation will be under contract with the State to provide for the collection and processing of monthly premiums. As part of its role, Healthy Kids will educate families about the cost sharing requirements and rules. The education will include how much money 5% of the family's income translates into in terms of dollars and cents. The education will instruct families in tracking their cost sharing expenditures on a monthly basis and to contact Healthy Kids should the expenditure exceed the previously determined amount of money or if family income should suddenly decrease. Healthy Kids will also monitor all co-pays on a quarterly basis via a cost sharing report generated by the health plan and the dental plan. Families who exceed the 5% cap will be formally notified by Healthy Kids and steps will be taken to either credit the family for future premium costs or reimburse the family for the amount of money in excess of the 5% amount.

The State is requesting clarification of its interpretation of the federal rules regarding cost-sharing relative to the inclusion of dental co-pays in the 5% cap. This clarification may be important for future program development. The State is aware of the prohibition of deductibles, coinsurance and other cost sharing, including co-pays, on well-baby and well-child preventive health care visits. Dental care is not specifically listed in Title XXI Section 2103 (C)(1) (a-d) as a category of basic services, nor in Section 2103 (C)(2) (a-d) as a category of additional services. The HCFA memo dated February 13, 1998 regarding cost-sharing does not help the State in clarifying the prevailing working assumption that dental co-pays must be counted as part of the 5% cap. The point for discussion is whether dental care is included in the nationally accepted, customary definition and/or guidelines for well-baby and/or well-child preventive health care. The Recommendations for Preventive Pediatric Health Care, as published by the Committee on Practice and Ambulatory Medicine, in consultation with the American Academy of Pediatrics (AAP), serves as the national standard in defining well-baby and well-child preventive health care. A review of the AAP periodicity table (copy enclosed) recommends an initial dental referral at the age of 12 months to 3 years. The AAP guidelines do not include any of the preventive or restorative dental care that the State is opting to include in its benefit package. As such, the State contends that dental services are not subject to the cost sharing provisions of Section 2103(e) of the Title XXI legislation.

14. Section 2103(e) of the Act prohibits the imposition of deductibles, coinsurance, or other cost sharing on well-baby and well-child care, including age-appropriate immunizations. The American Academy of Pediatric Dentistry guidelines include dental sealants in defining preventive/well child services for the purposes of cost-sharing. In your summary of dental benefits, the State has indicated that dental sealants have a 50% co-pay. Since no copay may be applied to this service, please amend your plan.

The State has opted to include sealants in the preventive dental service benefit.

Section 9. Strategic Objectives and Performance Goals for the Plan Administration

15. Section 9.10. If the State provides coverage to a child found to be presumptively eligible for Phase II and is then later found ineligible for either Phase II or Medicaid, the expenditures will count against the State's 10% limit on expenditures for administrative and certain other activities. Has the State included projections for these expenditures when calculating the 10% limit in the budget? Please provide further clarification of how the State will report and claim expenditures for presumptive eligibility.

During the initial development of the State's Title XXI plan, when many questions surrounded the 10% administrative limit, the State did not include projections ~~for~~ presumptive eligibility expenditures when calculating the 10% limit in the budget. Since that time, the State has attended a workshop sponsored by the HCFA Region I Office which helped to refine the State's 10% administrative budget.

The State will be claiming expenditures related to presumptive eligibility against the 10% administrative limit. The State will be assuming all who apply to be eligible and report on an exception basis; meaning that once the presumptive eligibility period has expired, the State will identify all those children found ineligible and adjust both medical and presumptive eligibility costs accordingly.

Please see Appendix 9.10 Budget. Please substitute these pages ~~for~~ the ones previously submitted.

16. Can the State please provide Section 9 and 10 assurances by checking off the appropriate boxes.

Please see "Section 9: Strategic Objectives and Performance Goals", found on page 17 ~~of~~ this document and "Section 10: Annual Reports and Evaluation", page 22 and substitute these pages ~~for~~ those previously submitted. The requested correction has been completed. All modifications are in bold print.

State of New Hampshire
Title XXI Children's Health Insurance Plan
Substitute Pages

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

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

- 1.1. **Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); OR**
- 1.2. **Providing expanded benefits under the State’s Medicaid plan (Title XIX); OR**
- 1.3. **A combination of both of the above.**

New Hampshire’s expansion of children’s health care coverage under Title XXI will occur in two phases and will include both providing expanded benefits under the State’s Medicaid plan and obtaining coverage that meets the requirements for a State Child Health Insurance Plan. This application requests authorization for both phases of the plan. The State of New Hampshire assures that the Title XXI State Plan will be conducted in compliance with all civil rights requirements.

In Phase I (to be implemented May 1998)¹ the state will expand 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 the federal poverty level (FPL). Income will be 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 percentage points 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. The state will be submitting a Title XIX plan amendment under separate cover.

In Phase II (to be implemented in January 1999), the state will provide insurance coverage through the development of a State Child Health Insurance Program in partnership with the New Hampshire Healthy Kids Corporation (Healthy Kids Corp.) for children ages 1 through 18 with family income greater than 185% and equal to or less than 300% of FPL. Income will be 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 percentage points 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. The plan includes an emphasis on perinatal care coverage for pregnant adolescent girls not previously served by the Healthy Kids Corp. It also provides a mechanism for the identification and referral of children with special health care needs to Title V programs.

¹ *New Hampshire recognizes that the enhanced Title XXI match will not be available for Phase 1 until this plan is approved by the Health Care Financing Administration.*

Section 3. General Contents of State Child Health Plan (Section 2101)(a)(4))

- 3.1 Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children (Section 2102)(a)(4))

As noted in Section I.3 and described in the state's Medicaid state plan amendment, the state will use Title XXI funds to expand coverage for newborns and infants who are currently covered up to 185% FPL. Title XXI will allow the state to increase its income eligibility for infants ages 0 to 1 whose family income is greater than 185% and equal to or less than 300% of FPL. Income will be calculated in the same manner used by the state for poverty level children (children with family income at or below 185% of FPL) with an additional disregard of 65 percentage points 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. This Medicaid expansion will be considered Phase 1 of New Hampshire's Title XXI Children's Health Insurance Plan (NH CHIP).

*To complement Phase I, the state is instituting a name change for all of the children's Medicaid Programs. The new program will be called **Healthy Kids - Gold**. It is hoped that changing the name of the program will reduce barriers due to stigma associated with Medicaid enrollment. Through Title XXI, families will 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. The state currently contracts with 2 managed care plans: Matthew-Thornton Health Plan (which has just merged with Blue Cross Blue Shield of New Hampshire), and Tufts Health Plan. An infant eligible for Title XXI and enrolled in a managed care plan will enjoy the same benefits package as those currently participating in the voluntary program. 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 will be on preventive and well-child care to give the child a healthy start.*

*Utilizing the provisions of Title XXI, the state will continue retroactive coverage, and implement cost sharing and guaranteed eligibility provisions for infants at greater than 185% FPL and equal to or less than 300% FPL (with the 65 percentage points income disregard) in Phase I. Consistent with the current Medicaid fee-for-service program, the state will provide three (3) months of retroactive coverage for services received in the 3 months prior to application date for Title XXI 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. **As prohibited by federal rule, there are no cost-sharing provisions for children enrolled in Phase I Healthy Kids - Gold (Medicaid Expansion).***

The state will enhance its current presumptive eligibility process to begin with Phase I. Training for community health centers, Early Intervention Sites, Title V and Title X agencies and hospitals is scheduled to be completed in May. A plan to offer training at other non-traditional presumptive eligibility sites is under development. The state will guarantee eligibility for infants who enroll in the voluntary managed care program for six (6) months.

In Phase 2 of the NH CHIP plan, the state will provide 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. Income will be 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 percentage points of the FPL for the family size involved as revised annually in the Federal Register. In no case will

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income be disregarded such that the resulting net income is less than or equal to 185% FPL. The federal eligibility standard is 235% FPL. Phase 2 will include health care services for pregnant adolescent girls. The state will purchase insurance for these children through Healthy Kids Corp., described in 2.2.2. To be consistent with Phase 1 and to differentiate this program from the non-subsidized Healthy Kids Corp. program, the Phase 2 program will be named Healthy Kids - Silver.

As noted in section 2.2.2, Healthy Kids Corp. currently contracts with 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. Healthy Kids Corp. selected Blue Cross Blue Shield and Northeast Delta Dental via a competitive bid process. 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. This is estimated at 5,000 children.

At the time of enrollment for Phase 2, a family can choose a primary care provider (PCP) from the Blue Cross Blue Shield provider network. If a PCP is not chosen, the family will be contacted by Healthy Kids Corp. and assisted with the selection process. The family can submit the first month's premium, which will be collected by Healthy Kids Corp. on behalf of the state. 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.

The Healthy Kids Corp.'s current benefits package does not include a maternity benefit. As such, the benefits package will be amended to include maternity care for pregnant adolescents. The state opts to bear full risk for the maternity benefit. As such the state will carry out a cost settlement after the adolescent has reached sixty (60) days postpartum.

The Healthy Kids Corp.'s current benefits package is not designed to address the comprehensive case management, care coordination and psychosocial supports that are needed by families in caring for a child with special health care needs. Services are required to ease the parental burden of caretaking responsibilities. In collaboration with community advisors, plans will be made to provide for the screening, referral and tracking of children with special health care needs. Coordination of resources will occur through the state's Special Medical Services Bureau, a Title V funded program that has the expertise to provide for the needs of these children.

Cost sharing provisions in Phase 2 include: A \$20 per child per month premium will be implemented for families whose family income is greater than 185% FPL and equal or less than 250% FPL. Families whose income is greater than 250% FPL and equal or less than 300% FPL will pay \$40 per child per month in premium. The State will cap monthly premium cost-sharing at \$100 per family. The State will contract with Healthy Kids Corp. for the collection and processing of the monthly premiums. Healthy Kids Corp. has made the premium payment process as user friendly as possible including mailing labels, change of address forms, use of coupon books and they are exploring electronic funds transfer for those families wishing to participate.

In accordance with federal regulations, eligibility may be terminated after sixty (60) days due to the non-payment of premium except for pregnant teens. In addition to termination of eligibility, a family who defaults on paying the monthly premium will be locked out from reapplying for a 3 month period beginning with the first day eligibility was terminated. The State will opt to waive payment for hardship and good cause. Good cause for non-payment of premiums shall exist when it is determined that either the recipient's family experiences a temporary or unexpected loss of income which prevents the family from paying the premium or if the recipient's family incurs and unexpected expense which prevents the family from paying the premium. Healthy Kids Corp. will

report to the state children whose eligibility is terminated and the circumstances of the termination. Six (6) month guaranteed eligibility will be available to children enrolled in Phase 2 **as long as the family does not default on paying the monthly premium.**

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

In addition to the monthly premium in Phase 2, a **\$5 co-pay for office visits, and a \$5 co-pay on generic and \$10 co-pay on brand name** prescriptive drugs will be implemented. A **\$25 fee for unauthorized or determined non-emergent use of an emergency room.** 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, dental check-ups, dental x-rays, cleanings and fluoride treatments.

The state will include in its contract with Healthy Kids Corp., 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: (Section 2102)(a)(4)

For children enrolled in Kids Care PLUS (Medicaid), the state will bear the responsibility for utilization controls. For infants in Phase 1 enrolled in the voluntary managed care program, the health plan conducts utilization reviews with state oversight. For children enrolled in Phase 2 in Kids Care via Healthy Kids Corp, the primary utilization control for covered services will be the responsibility of the managed care organization, specifically Blue Cross Blue Shield of New Hampshire. The contract with Blue Cross Blue Shield will include a definition of medical necessity and utilization management requirements, including clinical staffing requirements. The plan will be 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 will be applied to children covered under Title XXI.

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

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))

4.1.1. [X] Geographic area served by the Plan: *Statewide*

4.1.2. [X] Age: *For Phase 1: Infants up to age 1.
For Phase 2: Children between ages 1 to 19.*

4.1.3. [X] Income: *Family income must be greater than 185% and equal to or less than 300% of the FPL. Income will be 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 percentage points 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 pay check 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 will not be a resource/assets test.*

4.1.5. [X] Residency: *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. [X] Access to or coverage under other health coverage: ***Children eligible for the Phase 1 Medicaid Expansion can be eligible regardless of whether they are covered under any other health insurance plan. Children who are eligible for Title XIX Medicaid, 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 Phase 2 Healthy Kids - Silver. An application for Phase 2 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, voluntary quit of employment, and the quit occurred for any of the good cause reasons specified in RSA 167:82 III (c) - (e) and discontinuation of coverage to all employees (regardless of income) by the employer.***

4.1.8. [X] Duration of eligibility: *In general, a child who has been determined eligible for **Healthy Kids - Silver or Healthy Kids - Gold** (Medicaid) and is enrolled in a managed care program in Phase 1 or Phase 2, shall remain eligible for 6 months unless the child attains the upper age limit, as appropriate, is no longer a resident of the state, or fails to pay premiums. Exceptions to this policy are previously*

noted. A child who has been determined eligible for the Phase 1 Medicaid Expansion, who obtains services under a fee for service option, has no special durational eligibility. Upon failure to meet eligibility requirements, action will be taken to terminate coverage.

The state may determine that an enrollee is not eligible if eligibility was a result of making a false statement, misrepresentation or concealment 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 shall be redetermined not more than 12 months after the effective date of eligibility and annually thereafter.

4.1.9. [] Other standards (identify and describe):

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))

4.2.1. [X] These standards do not discriminate on the basis of diagnosis.

4.2.2. [X] 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. [X] 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))

The state will create a single, seamless application process for Healthy Kids - Silver and Healthy Kids - Gold (Medicaid). For Phase 1 (May, 1998), families can continue to go to the established qualified sites or the local district offices to make application and have eligibility determined. In addition, the Medicaid 800-P shortforms 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) per the state's presumptive eligibility process.

The state is also waiving the face-to-face interview requirement. With the implementation of Phase 2 the state will begin using a single application for both programs. The state will also establish a central unit within the Department of Health and Human Services where applications can be mailed. The Department will determine eligibility for both programs. This unit will be operational with the implementation of Phase 2 (January, 1999). The state will make applications available via the Department's web site.

Eligibility for Healthy Kids - Silver and Healthy Kids - Gold (Medicaid) will be determined based on information collected on the application form, which will include name, address, date of birth, residency, family income, employment, and insurance (both current and in the previous six months). Eligibility for Healthy Kids - Gold (Medicaid) will also require the furnishing of a Social Security number for the child.

The state will verify address and income and whether the child is eligible ~~for~~ **Healthy Kids - Gold** (Medicaid). If the responses to questions regarding insurance coverage appear inconsistent, the state will contact the employer **or** insurer, as appropriate. 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. The state will serve as the enrollment counselor ~~for~~ these children, providing technical support during the enrollment process.

If a child is not eligible ~~for~~ Medicaid **because the child does not meet programmatic requirements**, but is eligible ~~for~~ Phase 2 **Healthy Kids - Silver** (including income, residence, and insurance requirements), he/she will be enrolled in Title XXI via Healthy Kids Corp. If a child is not eligible ~~for~~ either program but may be eligible ~~for~~ the non-subsidized Healthy Kids Corp. program, the state will refer the child to Healthy Kids Corp. **Children whose eligibility ~~for~~ Healthy Kids - Gold (Medicaid) cannot be determined due to the lack of information needed to render an eligibility decision or failure to meet a procedural requirement, will not be screened ~~for~~ Title XXI eligibility. All efforts will be made to work with families to complete the eligibility process including working with community partners who may have on-going contact with families. Outreach efforts will also address this issue.**

Eligibility information ~~for~~ children determined eligible ~~for~~ **Healthy Kids - Silver** will be entered into the state system and sent to Healthy Kids Corp. Healthy Kids Corp. will complete enrollment, including sending a letter notifying the family ~~of~~ the child's eligibility (including the effective date), materials about Healthy Kids Corp. 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** (Medicaid). The state will mail a form to enrollees to obtain information necessary to redetermine eligibility. **Also**, as noted in section 4.1.8, enrollees will be required to notify Healthy Kids Corp. ~~of~~ any change in circumstance that could affect continued eligibility ~~for~~ coverage. If 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).

4.4. Describe the procedures that assure:

- 4.4.1. Through intake and follow-up screening, only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))

As noted in section 4.3, the state will determine eligibility ~~for~~ both Healthy Kids - Silver **and** Healthy Kids - Gold (Medicaid). As part ~~of~~ the determination for Healthy Kids - Silver, the state will verify that an applicant is not a Medicaid beneficiary (through on-line access to the state's 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

The application will include questions about insurance coverage. If a child has insurance coverage, he/she will not be eligible to receive coverage via Phase 2 ~~of~~ the State's Title XXI program. Also, ~~i~~ 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 Phase 2 ~~of~~ the State's Title XXI program. Children currently enrolled in Healthy Kids Corp. who meet the remaining eligibility guidelines, will be grandfathered into Kids Care.

4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))

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

4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))

The application process will include collecting information about current coverage and coverage in the past six months. Children currently covered will not be eligible for Healthy Kids - Silver except ~~for~~ children currently enrolled in Healthy Kids Corp. who meet the remaining eligibility guidelines, will be grandfathered into Healthy Kids - Silver.

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 (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, voluntary quit ~~of~~ employment, and the quit occurred for any ~~of~~ the good cause reasons specified in RSA 167:82 III (c) - (e), and discontinuation of coverage to all employees (regardless of income) by the employer.

4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))

New Hampshire does not have any federally recognized tribes.

- 4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))

The state will coordinate with Healthy Kids Corp in the implementation of the Title XXI plan to the fullest extent possible to reduce duplication of efforts and to provide quality health care coverage to New Hampshire's uninsured children.

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

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. YES

8.1.2. NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income:

(Section 2103(e)(1)(A))

8.2.1. Premiums: *Children in Phase 2 with family income greater than 185% and less than or equal to 250% of the FPL will be required to pay a premium of \$20 per child per month. Children in Phase 2 with family income greater than 250% FPL and less than or equal to 300% FPL will be required to pay a premium of \$40 per child per month. The State will cap the family monthly premium at \$100 such that no family will pay more than \$100 in any given month for premiums. Premiums for Phase 2 will be collected by Healthy Kids Corp. per a contract agreement to be entered into by the state and Healthy Kids Corporation.*

8.2.2. Deductibles: *Not applicable*

8.2.3. Coinsurance: *Not applicable*

8.2.4. Other: *For Phase 2, there will be a \$5 co-pay for provider office visits, and a \$5 co-pay on generic and \$10 co-pay on brand name prescription drugs. There will be a \$25 co-pay for non-emergent and unauthorized emergency room visits. There will be no co-pay for preventive health and/or well child visits, dental check-ups, dental x-rays, cleanings and fluoride treatments.*

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income:

Information about premiums and co-pays will be included in the outreach/education materials. Both the state and Healthy Kids Corp. will provide information on the cost sharing requirements to enrollees as well as to the provider community.

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of 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))

8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))

8.4.3. No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

8.4.4. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))

8.4.5. No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))

8.4.6. 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 this title. (Section 2105(c)(6)(A))

8.4.7. [X] 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))

8.4.8. [X] 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))

8.4.9. [X] 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))

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 annual income for the year involved: (Section 2103(e)(3)(B))

The Healthy Kids Corporation will be under contract with the State to provide for the collection and processing of monthly premiums. As part of its role, Healthy Kids will educate families about the cost sharing requirements and rules. The education will include how much money 5% of the family's income translates into in terms of dollars and cents. The education will instruct families in tracking their cost sharing expenditures on a monthly basis and to contact Healthy Kids should the expenditure exceed the previously determined amount of money or if family income should suddenly decrease. Healthy Kids will also monitor all co-pays on a quarterly basis via a cost sharing report generated by the health plan and the dental plan. Families who exceed the 5% cap will be formally notified by Healthy Kids and steps will be taken to either credit the family for future premium costs or reimburse the family for the amount of money in excess of the 5% amount.

8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:

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

8.6.2. [] 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 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe if applicable.

Section 9. Strategic Objectives and Performance Goals for the 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))

The strategic objectives are to: 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))

- 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 Healthy Kids Corp. 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.

3) *Maximize enrollment in Healthy Kids - Gold and Healthy Kids - Silver 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))

1) *Increase the number of low-income children in New Hampshire who are insured. This will be measured using CPS data sample.*

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 (Medicaid) through outreach, a single point of entry, a simplified application process, and continuous eligibility - 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 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))

9.5. The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))

The Department 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. The baseline number will be calculated using CPS data (although the sample size is very small). By March 31, 2000 the state will submit an evaluation of the items listed in 10.2. The state will contract with a consulting firm chosen via a competitive RFP process that has the expertise to conduct the evaluation and analysis. The evaluator will assist the state in determining how to analyze the effectiveness of various elements. However, characteristics of the children enrolled in the plan can be collected from the application forms, and quality will be evaluated using the measures identified in sections 7.1.2 and 9.3. Other elements may be analyzed based on surveys and interviews.

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))

9.7. The state 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))

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 1115 (relating to waiver authority)

9.8.5. Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI

- 9.8.6. [X] Section 1124 (relating to disclosure of ownership and related information)
- 9.8.7. [X] Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8. [X] Section 1128A (relating to civil monetary penalties)
- 9.8.9. [X] Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10[X] 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))

A multidisciplinary group comprised of Department staff and representatives from the Governor's Office and Healthy Kids Corp. worked to develop and review the initial conceptual model. The Department met with the Healthy Kids Corp. 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 have been held with the Board of Directors. The Department also met with representatives from Blue Cross Blue Shield of New Hampshire.

Since that time a series of public meetings have been held. 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. Unanswered questions were followed up on by Department staff

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>
<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>
<i>May 21, 1998</i>	<i>NH Welfare Directors/NH Municipal Association</i>

In addition to the public meetings previously noted, the state created a site on the Department of Health & Human Services 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 webpage. A copy of the final working draft of the application was made directly available to a variety of advocacy groups and community leaders.

An outcome of the public meetings included a plan to ensure on-going public involvement. Several individuals indicated an interest in working through a variety of operational issues with the Department. These individuals were invited to attend workgroup meetings focused on eligibility and enrollment, benefits design including cost-sharing and outreach efforts. The outreach effort will be a part of a much larger Departmental outreach plan which will be developed with our community partners. This will prove vital if we are to reach the consumers directly and in a timely manner.

As suggested by advocates attending the public meetings, once the workgroups complete their tasks and the state moves into an implementation phase, the primary point of contact will be through the Commissioner's Managed Care Advisory Group, the Commissioner's Consumer Policy Advisory Board which have diverse representation and the Health Planning District Council meetings. The Healthy Kids Corp. Board of Directors has agreed to continue to play an on-going advisory role. The state will also maintain a point person in the Department of Health & Human Services who can be reached by mail, phone or email. The state will utilize its employee newsletter for updates on the NH CHIP plan and to invite participation at any focus groups or meetings scheduled on the plan. This newsletter enjoys a vast circulation beyond the state employees. Lastly, the state, upon approval of this application, will conduct a series of media activities including radio and television shows, as well newspaper and newsletter articles.

- 9.10.** Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

See Appendix 9.10. This budget is based upon the new cost-sharing amounts.

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))
- 10.1.1.[X]** 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
 - 10.1.2.[X]** Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.
- 10.2. State Evaluations.** The state assures that by **March 31, 2000** it will submit to the Secretary an evaluation of each of the items described and listed below: (Section 2108(b)(A)-(H))
- 10.2.1.[X]** An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.
 - 10.2.2.[X]** A description and analysis of the effectiveness of elements of the state plan, including:
 - 10.2.2.1.[X]** The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;
 - 10.2.2.2.[X]** The quality of health coverage provided including the types of benefits provided;
 - 10.2.2.3.[X]** The amount and level (including payment of part or all of any premium) of assistance provided by the state;
 - 10.2.2.4.[X]** The service area of the state plan;
 - 10.2.2.5.[X]** The time limits for coverage of a child under the state plan;
 - 10.2.2.6.[X]** The state's choice of health benefits coverage and other methods used for providing child health assistance, and
 - 10.2.2.7.[X]** The sources of non-Federal funding used in the state plan.
 - 10.2.3. [X]** An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.
 - 10.2.4. [X]** A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
 - 10.2.5. [X]** An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
 - 10.2.6. [X]** A description of any plans the state has for improving the availability of health insurance and health care for children.

10.2.7. **[X]** Recommendations for improving the program under this Title.

10.2.8.[X] Any other matters the state and the Secretary consider appropriate.

10.3. **[X]** The state assures it will comply with future reporting requirements as they are developed.

10.4. **[X]** 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.

Estimated Budget for CHIP Expansion

Phase 1:	0 - 1 year olds	1 < 19 year olds	Pregnant & < 19	Total
Federal Fiscal Year 1998 (May 1, 1998)	Uninsured Children	Uninsured Children	Uninsured Children	
Enrollment: (Ave. per month)	51			51
Total Member Months	254			254
Cost per Member per Month	\$ 115.00			\$ 115.00
Subtotal Grants	\$ 29,152.50			\$ 29,152.50
Administrative costs (10%)	\$ 3,239.17			\$ 3,239.17
Total Expenditures	\$ 32,391.67			\$ 32,391.67
Federal Share (65%)	\$ 21,054.58			\$ 21,054.58
State Share (35%)	\$ 11,337.08			\$ 11,337.08
Total Revenue	\$ 32,391.67			\$ 32,391.67
CHIP Allotment (Federal)				\$ 11,461,349.00
Surplus (Federal)				\$ 11,440,294.42
Phase 2				
Federal Fiscal Year 1999 (Oct 1, 1998)				
Enrollment: (Ave. per month)	146	2,595.55	155.83	2,741.31
Total Member Months (12mo/9mo/9mo)	1,749	23,360.0	1,402.43	25,109.10
Cost per Member per Month	\$ 117.30	\$ 59.31	\$ 301.00	\$ 89.06
Subtotal Grants	\$ 205,175.30	\$ 1,385,388.90	\$ 422,129.93	2,012,694.12
Administrative costs (10%)	\$ 22,797.26	\$ 153,932.10	\$ 46,903.33	223,632.68
Total Expenditures	\$ 227,972.55	\$ 1,539,321.00	\$ 469,033.25	\$ 2,236,326.80
Federal Share (65%)	\$ 148,182.16	\$ 1,000,558.65	\$ 304,871.61	\$ 1,453,612.42
State Share (35%)	\$ 79,790.39	\$ 538,762.35	\$ 164,161.64	\$ 782,714.38
Total Revenue	\$ 227,972.55	\$ 1,539,321.00	\$ 469,033.25	\$ 2,236,326.80
CHIP Allotment (Federal)				\$ 11,461,349.00
Surplus (Federal)				\$ 10,007,736.58
Federal Fiscal Year 2000 (Oct 1, 1999)				
Enrollment: (Ave. per month)	215	3,836.90	230.35	4,052.38
Total Member Months (12mo)	2,586	46,042.8	2,764.20	48,628.50
Cost per Member per Month	\$ 119.65	\$ 60.85	\$ 307.02	\$ 90.47
Subtotal Grants	\$ 309,368.66	\$ 2,801,527.51	\$ 848,664.68	3,959,560.86
Administrative costs (10%)	\$ 34,374.30	\$ 311,280.83	\$ 94,296.08	439,951.21
Total Expenditures	\$ 343,742.96	\$ 3,112,808.35	\$ 942,960.76	\$ 4,399,512.06
Federal Share (65%)	\$ 223,432.92	\$ 2,023,325.43	\$ 612,924.49	\$ 2,859,682.84
State Share (35%)	\$ 120,310.04	\$ 1,089,482.92	\$ 330,036.27	\$ 1,539,829.22
Total Revenue	\$ 343,742.96	\$ 3,112,808.35	\$ 942,960.76	\$ 4,399,512.06
CHIP Allotment (Federal)				\$ 11,461,349.00
Surplus (Federal)				\$ 8,601,666.16
Federal Fiscal Year 2001 (Oct 1, 2000)				
Enrollment: (Ave. per month)	260	4,626.85	277.78	4,886.69
Total Member Months (12mo)	3,118	55,522.2	3,333.30	58,640.25
Cost per Member per Month	\$ 122.04	\$ 62.42	\$ 313.16	\$ 92.65
Subtotal Grants	\$ 380,523.45	\$ 3,465,526.86	\$ 1,043,857.56	4,889,907.88
Administrative costs (10%)	\$ 42,280.38	\$ 385,058.54	\$ 115,984.17	543,323.10
Total Expenditures	\$ 422,803.84	\$ 3,850,585.40	\$ 1,159,841.73	\$ 5,433,230.97
Federal Share (65%)	\$ 274,822.49	\$ 2,502,880.51	\$ 753,897.13	\$ 3,531,600.13
State Share (35%)	\$ 147,981.34	\$ 1,347,704.89	\$ 405,944.61	\$ 1,901,630.84
Total Revenue	\$ 422,803.84	\$ 3,850,585.40	\$ 1,159,841.73	\$ 5,433,230.97
CHIP Allotment (Federal)				\$ 11,461,349.00
Surplus (Federal)				\$ 7,929,748.81

Federal Fiscal Year 2002 (Oct 1, 2001)					
Enrollment: (Ave. per month)		292	5,191.10	311.65	5,482.63
Total Member Months (12mo)		3,498	62,293.2	3,739.80	65,791.50
Cost per Member per Month	\$	124.48	\$ 64.02	\$ 319.42	\$ 94.88
Subtotal Grants	\$	435,467.33	\$ 3,987,959.25	\$ 1,194,580.41	\$ 5,618,006.99
Administrative costs (10%)	\$	48,385.26	\$ 443,106.58	\$ 132,731.16	\$ 624,223.00
Total Expenditures	\$	483,852.59	\$ 4,431,065.83	\$ 1,327,311.57	\$ 6,242,229.98
Federal Share (65%)	\$	314,504.18	\$ 2,880,192.79	\$ 862,752.52	\$ 4,057,449.49
State Share (35%)	\$	169,348.41	\$ 1,550,873.04	\$ 464,559.05	\$ 2,184,780.49
Total Revenue	\$	483,852.59	\$ 4,431,065.83	\$ 1,327,311.57	\$ 6,242,229.98
CHIP Allotment (Federal)				\$	11,461,349.00
Surplus (Federal)				\$	7,403,899.51

Notes:

Maternity Distinct means costs are separated for maternity related coverage and enrollment is counted twice between groups
 0 - 1 year olds are covered as a Medicaid expansion with full Medicaid coverage.
 1 < 19 year olds are covered through Healthy Kids Corp. with a federal employee actuarial equivalent benefit package.
 Pregnant teens less than 19 years of age will have a full Medicaid equivalent benefit package under Healthy Kids Corp and a separate premium which is cost settled at 100% of allowable costs.
 1 < 19 year old coverage begins January 1, 1999 under Phase 2.
 Co-payments are not included in the costs and the cost is net of a \$20/\$40 per member per month premium considered 70% collectible
 Premiums are capped at \$20 per person for those under 250% PL and \$40 per person for those under 300% PL.
 No co-payments or premiums are applied to the Medicaid expansion group 0 - 1 year olds.
 Medicaid costs are extracted from the fee for service costs of the poverty level population between 170% & 185% PL.
 HKC premiums are extracted from the HKC current premiums adjusted for CHIP estimates.
 Costs are inflated 2% per year.
 Differences due to rounding.
 Source file: CHIP7.xls

Administration and Community Outreach

	Phase 1 FFY 1998 (May1, 1998)	Phase 2 FFY 1999 (Oct1, 1998)	Notes
Administrative:			
System Development		\$ 30,000.00	MMIS modification estimated cost.
Community Outreach:			
Contracted Services	\$ 3,239,177	\$ 189,025.67	1998 and 1999 estimated for presumptive eligibility and outreach costs.
Total Admin & Outreach	\$ 3,239,177	\$ 223,632.68	Limited to 10% of Grant Services

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC HEALTH CARE

Committee on Practice and Ambulatory Medicine

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

These guidelines represent a consensus by the Committee on Practice and Ambulatory Medicine in consultation with national committees and sections of the American Academy of Pediatrics. The Committee emphasizes the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include antenatal guidance and pertinent medical history. Every infant should have a newborn evaluation after birth.

AGE	INFANCY ²					EARLY CHILDHOOD ³					MIDDLE CHILDHOOD ³					ADOLESCENCE ³												
	NEWBORN ¹	2-4d ²	1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	11y	12y	13y	14y	15y	16y	17y	18y	19y	20y	21y
HISTORY	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Height and Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Blood Pressure	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Vision	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hearing ⁴	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT/ ⁵	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION ⁶	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES - GENERAL ⁷	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hereditary/Metabolic Screening ⁸	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Immunization ¹¹	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Lead Screening ¹²	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hematoctrit or Hemoglobin Urinalysis	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES - PATIENTS AT RISK	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tuberculin Test ¹⁵	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Cholesterol Screening ¹⁶	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
STD Screening ¹⁷	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Pelvic Exam ¹⁸	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
ANTICIPATORY GUIDANCE ¹⁹	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Injury Prevention ²⁰	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
INITIAL DENTAL REFERRAL ²¹	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

1. Breastfeeding encouraged and instruction and support offered.
2. For newborns discharged in less than 48 hours after delivery.
3. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
4. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
5. If the patient is uncooperative, rescreen within six months.
6. Some experts recommend objective appraisal of hearing in the newborn period. The Joint Committee on Infant Hearing lists identified patients at significant risk for hearing loss. All children meeting these criteria should be objectively screened. See the Joint Committee on Infant Hearing 1994 Position Statement.
7. By history and appropriate physical examination if suspected, by specific objective developmental testing.

8. At each visit, a complete physical examination is essential, with infant toilet and/or older child undressed and actively engaged.
9. These may be modified, depending upon entry point into schedule and individual need.
10. Metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
11. Schedule(s) per the Committee on Infectious Diseases, published periodically in *Pediatrics*. Every visit should be an opportunity to update and complete a child's immunizations.
12. Blood lead screen per AAP statement "Lead Poisoning: From Screening to Primary Prevention" (1995).
13. All menarcheing adolescents should be screened.
14. Contraception counseling for adolescents for tuberculin in infants and children (1994). TB testing per AAP statement "Screening for Tuberculosis in Infants and Children" (1994). TB testing should be done upon recognition of high risk factors. If results are negative but high risk situation continues, testing should be repeated on an annual basis.
15. All menarcheing adolescents should be screened.
16. Cholesterol screening for high risk patients per AAP "Statement on Cholesterol" (1992). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
17. All sexually active patients should be screened for sexually transmitted diseases (STDs).
18. All sexually active females should have a pelvic examination. A pelvic examination and routine PAP smear should be offered as part of preventive health maintenance between the ages of 18 and 21 years.
19. Appropriate education and counseling should be an integral part of each visit for care.
20. From Item 1 to Item 12, refer to AAP's injury prevention program (TIP) as described in "A Guide to Safety Counseling in Office Practice" (1994).
21. Earlier initial dental evaluations may be appropriate for some children. Subsequent examinations as prescribed by dentist.

Key: • = to be performed * = to be performed for patients at risk G = subjective, by history O = objective, by a standard testing method ← → = the range during which a service may be provided, with the dot indicating the preferred age.

NB: Special chemical, immunologic, and endocrine testing is usually carried out upon specific indications. Testing other than newborn (e.g., biopsy, sickle disease, etc.) is discretionary with the physician.

The recommendations in this publication do not include an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. © 1996 American Academy of Pediatrics.