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 Mexico_____________________________________
(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))**

_______________________________Robert Maruca,_______________________________
(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:	Robert T. Maruca	Position/Title:	Director, Medical Assistance Division
Name:	Robert D. Beardsley	Position/Title:	Chief, Client Services Bureau
Name:	Widmer, Sylvija	Position/Title:	Chief, Fiscal Management Bureau

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 (or minutes) 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, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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.

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))

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)

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: March, 1999

Implementation date: March, 1999

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))

In 1996 there were an estimated 109,000 uninsured children in New Mexico, based on HSD/MAD analysis of a recently released Consumer Population Survey (CPS) estimates and Medicaid program data. This estimate reflects most, if not all, of the expansion of Medicaid eligibility to children in families up to 185% federal poverty level (FPL), which began in April 1995. The expansion to 185% FPL has resulted in over 38,000 additional children with Medicaid coverage. Sixteen percent of children enrolled in Medicaid for children up to 185% FPL had private health insurance at time of enrollment. Most recent available figures indicate that 25% of those with private insurance had dropped the coverage.

In New Mexico, employment-based health insurance for children has been about 48% to 50% for the past seven years, according to HSD/MAD analysis of the CPS statistics for 1996. Approximately 86% or 94,000 uninsured children were in families at or below 185% FPL, and about 5% or 5,500 uninsured children are in families with incomes at 186% to 235% FPL. The most recent statistics on the percentage of uninsured children in New Mexico by percent of FPL come from the 1993 Robert Wood Johnson Foundation Family Survey, and the percentages of uninsured children above and below 185 come from statistical analysis of that survey. The percentages are applied to the estimates of uninsured children to arrive at the number of uninsured children in families with incomes at or below 185% FPL, and those uninsured children in families with incomes 186% to 235% FPL.

DEMOGRAPHIC SUMMARY TABLE OF CHILDREN IN NEW MEXICO

% FPL	Medicaid	Uninsured	Total
< 100%	137,760	55,590	188,650
101 – 133%	14,760	21,800	64,680
134 – 185%	11,480	13,080	53,900
186 – 200%	0	2,180	16,170
201 –235%	0	3,270	21,560
> 235%	0	13,080	194,040

AGE			
0 – 1	13,120	n/a	26,950
1 – 5	55,760	n/a	145,530
6 – 12	60,680	n/a	199,430
13 – 18	34,440	n/a	167,090

RACE & ETHNICITY			
Native American	19,680	5,450	70,070
Asian/Pac. Island	1,640	(2)	(2)
Black, not Hispanic	4,920	2,180	16,170
Hispanic	96,760	80,660	242,550
White, not Hispanic	37,720	20,710	210,210
Unknown	3,280		

URBAN/RURAL			
MSA	77,080	n/a	280,280
Non-MSA	86,920	n/a	258,720

TOTAL	164,000	109,000	539,000

n/a – Not Available
1) Estimates are current, based upon most current data available using multiple sources. Margin of error not calculated.
2) Numbers too small to estimate percent of population rounds to zero.
Sources: BBER/UNM, US Census Bureau, NM Human Services Dept. /Medical Assistance Div., NM Health Policy

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):

Identification and enrollment of Children in Medicaid occurs through a variety of ways.

Medicaid applications are processed in approximately 35 Income Support Division (ISD) offices throughout New Mexico and in most cases involve face-to-face interviews.

Out-Stationed Eligibility Staff
Under MOSAA (Medicaid On Site Application Assistance), statewide Disproportionate Share Hospitals (DSH), Indian Health Service (HIS), and Federally Qualified Health Centers (FQHCs) have trained staff assisting clients in completion of Medicaid applications, gathering of necessary documentation, and routing of applications to ISD for processing.

Salud! Telephone Bank
These telephone lines provide information regarding Salud! Enrollment and application processing.

Telephone Page Listings
Current information for local ISD offices is contained in local telephone directories in the government blue pages section. Numbers are also given for the primary care network and Salud!

Food Stamps
Individuals applying for food stamps are tested for eligibility for Medicaid during the same interview.

Temporary Assistance to Needy Families (TANF)
Individuals eligible for TANF are made Medicaid eligible by virtue of their certification for TANF. Those who apply and are determined ineligible for TANF are tested to determine their eligibility for Medicaid under other eligibility categories. Former TANF recipients receiving transitional Medicaid are sent an automated notice telling them to

contact their local ISD office if they wish to reapply for Medicaid when the transitional Medicaid ends.

Newborns of Medicaid Eligible Mothers
Enrollment in Medicaid is automatic for the majority of newborns of Medicaid-eligible mothers. When the medical facility notifies an ISD office about the birth of the child to a Medicaid-eligible mother, the ISD office establishes eligibility for the child. The ISD office then notifies the mother and provider of the eligibility. The child is subsequently enrolled in Salud!

Supplemental Security Income
SSI eligible persons are automatically enrolled in Medicaid in New Mexico. Disability Determination Services in the New Mexico State Department of Education make disability determinations for SSI and SSI related Medicaid categories.

Foster Care
For children who are removed from their households by court order through the Children Youth and Families Department (CYFD), Medicaid is provided through foster care if the child was eligible for Medicaid prior to being removed from the household or if the child is determined to be Medicaid eligible by CYFD standards. Medicaid is also provided under TANF limits, to children under 18 placed by a district court in the managing conservatorship of CYFD as a result of findings of abuse or neglect by CYFD.

Child Support
The Child Support Enforcement Division of HSD pursues the non-custodial parent for financial and/or medical support to supplement and/or replace state liability. This office also utilizes the Third Party Liability system to seek premium reimbursement for cases where medical coverage is provided.

EPSDT
Managed Care Organizations are responsible for ensuring that EPSDT requirements are met by their network providers. Each MCO has an EPSDT Coordinator who trains providers, conducts outreach, and tracks screens to ensure periodicity and proper referral.

EPSDT
Brochures in both English and Spanish are distributed to, and available in, ISD offices.

The Salud! monthly newsletter to providers, state agencies, advocacy groups, and interested parties provides information on enrolling in the program, services, up-coming events and general information.

The Families First Program at the Department of Health (DOH) provides Case Management to assist pregnant women and infants access all available health care resources, including referral to Medicaid when appropriate.

Children's Medical Services (CMS) is New Mexico's program for children with special health care needs and is funded in part through Title V. Case Management is provided for these children and referrals are made to necessary services and to Medicaid when appropriate.

CMS also administers the Healthier Kids Fund (HDF). HKF covers primary health care for children without health insurance or with insurance with a very high deductible. This program has been funded through general fund money appropriated by the New Mexico State Legislature.

CMS requires that potentially Medicaid eligible families apply for Medicaid within 60 days of completing a CMS application and be denied Medicaid before accessing on-going services. Social Workers must assist and support families in the process by providing application forms and helping to complete them. CMS staff provides regular outreach to families, providers, schools, community groups, and others about services and always includes information about Medicaid programs. CMS has staff and offices statewide in all major cities and towns and has regular outreach coverage to numerous smaller, more rural communities.

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 New Mexico Health Insurance Alliance is a consortium of independent insurance companies offering insurance to small businesses with fewer than 50 employees. Employers and employees and their children who otherwise would find health insurance unaffordable may access coverage through this program.

The Comprehensive Health Insurance Program (CHIPS) is a program designed for individuals who are uninsurable or whose preexisting condition precludes their obtaining affordable coverage. Individuals pay

premiums based upon a sliding fee scale (usually around 55%) and insurance companies involved in this initiative pay the remaining 45%.

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 New Mexico Title XXI program involves expanding Medicaid for children birth to ~~18~~ 19 years of age from the current ceiling of 185% FPL, to 235% FPL. Therefore the Title XXI program will continue the existing methods, mechanisms, and processes currently used by the Medicaid program to insure coverage of only targeted low-income children.

When New Mexico expanded coverage to 185% FPL, 25% of those children who had private health insurance at the time of enrollment dropped that coverage. Therefore we propose to implement and enforce measures to discourage this practice. Children will be ineligible for six (6) months from the date on which creditable health coverage was dropped. Exceptions to that would be an involuntary loss of insurance, including: the dropping of coverage by the employer; a catastrophic illness in a family possessing limited coverage; underinsured with special needs; and a change in marital status or any other change in circumstances which may inadvertently effect coverage.

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))

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

Section 4. Eligibility Standards and Methodology. (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:
4.1.2. ☐ Age:
4.1.3. ☐ Income:
4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):
4.1.5. ☐ Residency (so long as residency requirement is not based on length of time in state) :
4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):
4.1.7. ☐ Access to or coverage under other health coverage:
4.1.8. ☐ Duration of eligibility:
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)) (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)

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 a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))

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))

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))

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))

4.4.4.1. ☐ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

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.

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.

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

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))

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)

New Mexico is implementing the Presumptive Eligibility (PE) option enacted by the Balanced Budget Act of 1997. The state's schedule for implementation of PE providers is as follows:

1st Round: HIS facilities, Disproportionate share Hospitals, Federally Qualified Health Centers, Schools, Department of Health public health clinics, and Children Youth and Families Department Child Care Bureau Staff.

Phase-in: July 1998: Bernalillo, Sandoval, Torrance, and Valencia counties

October 1998: Rest of State

2nd Round: Non-DSH hospitals, Primary Care Providers and pediatric practices who are contracted with at least one Salud! HMO, and Head Starts

Phase-in: January 1999: Bernalillo, Sandoval, Torrance, and Valencia counties

April 1999: Rest of the State

Provider enrollment procedure includes application, initial and periodic training, and signing of a provider agreement. The provider agreement addresses:

- Initial and periodic training requirements
- Requirement to do MOSAA for each PE determination
- Same-day transmission of the eligibility information to the Medcaid fiscal agent (FAX transmission if a prescription was issued),

- Update fiscal agent system daily so as to allow health care access on the part of the participants; and
- AVRS or MEVS check for each applicant, for purposes of verification that current eligibility does not already exist.

MOSAA

The requirement that the PE providers complete a MOSAA application with each PE determination will further assure Medicaid eligibility access. The MOSAA process allows the PE providers to assist the PE recipient in completion of the actual Medicaid application and gathering of the necessary documentation. The PE provider documents interview information and the application package is forwarded to the local ISD office for final processing.

PR Campaign

HSD is partnering with the Department of Health to provide a publicity campaign via a private contractor, Belinoff and Bagley. CHIPS outreach will be coordinated with other public health outreach.

Salud! Newsletters

The Department issues Salud! Newsletters with a wide and varied circulation list. These newsletters address CHIPS implementation.

Assuring Access to Native Americans

- PE tools will allow PE/MOSAA determinations by HIS facilities in the first round.
- All HIS facilities in the state are currently trained and actively participating in the MOSAA program.
- HSD/MAD participation in ongoing meetings with the Albuquerque Area Indian Health Board, Inc., assures coordination with tribal entities.
- New Mexico has, for some time, worked to assist Native Americans in their efforts to design and implement a Native American HMO. Such an HMO would provide appropriate, culturally sensitive outreach activities.

Robert Wood Johnson Foundation Grant Application

A grant application to the Robert Wood Johnson Foundations for a $1,000,000., three year, matchable grant for outreach and coordination was a joint effort among HSD, DOH, CYFD, State Department of Education (DOE), New Mexico Health Policy Commission, New Mexico Advocates for Children and Families, New Mexico Hospitals and Health Systems Association, New Mexico Primary Care Association, New Mexico Pediatric Society, New Mexico Medical Society, Indian Health Service, and the Human Needs Coordinating Council.

Twelve-Months Continuous Eligibility Option

New Mexico is implementing, statewide, the twelve-months continuous eligibility option enacted by the BBA, effective July 1, 1998. This option will enhance continuity of care for children by guaranteeing eligibility for a twelve-month period regardless of changes in income.

Simplified Application

New Mexico has implemented a simplified application appropriate for use by MAWC applicants.

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.

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))
6.2.2. ☐ Outpatient services (Section 2110(a)(2))
6.2.3. ☐ Physician services (Section 2110(a)(3))
6.2.4. ☐ Surgical services (Section 2110(a)(4))
6.2.5. ☐ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
6.2.6. ☐ Prescription drugs (Section 2110(a)(6))
6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))
6.2.8. ☐ Laboratory and radiological services (Section 2110(a)(8))
6.2.9. ☐ Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))
6.2.10. ☐ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
6.2.11. ☐ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)
6.2.12. ☐ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
6.2.13. ☐ Disposable medical supplies (Section 2110(a)(13))
6.2.14. ☐ Home and community-based health care services (See

instructions) (Section 2110(a)(14))

6.2.15. ☐ Nursing care services (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))

6.2.18. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

6.2.19. ☐ Outpatient substance abuse treatment services (Section 2110(a)(19))

6.2.20. ☐ Case management services (Section 2110(a)(20))

6.2.21. ☐ Care coordination services (Section 2110(a)(21))

6.2.22. ☐ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

6.2.23. ☐ Hospice care (Section 2110(a)(23))

6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))

6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.26. ☐ Medical transportation (Section 2110(a)(26))

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))

6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

6.3 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)

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

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

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

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

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

6.4.2.1. Purchase of family coverage is cost-effective 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))

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)
7.1.1. ☐ Quality standards
7.1.2. ☐ Performance measurement
7.1.3. ☐ Information strategies
7.1.4. ☐ Quality improvement strategies

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))

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

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: None
8.2.2. Deductibles: None
8.2.3. Coinsurance or copayments: Co-Payments will be applicable to children in all families (except Native Americans) between 186% - 235% FPL. The co-payment schedule is as follows:

- $5.00 per physician visit
- $5.00 per visit outpatient services (clinic, therapy)
- $15.00 per urgent care and emergency room visit
- $25.00 per inpatient hospital admission
- $15.00 per outpatient hospital services
- $ 2.00 per prescription
- $ 5.00 for dental visits

Prenatal and preventive care will be exempt from the co-payment requirement.

In addition, services provided at Indian Health Services facilities, Urban Indian providers, and tribal 638's are also exempt.

Application of the yearly maximum payment of co-payment amounts will not exceed the following standards, based upon FPL income status at the time of initial eligibility determination or redetermination:

- 186% - 200% 3%
- 201% - 215% 4%
- 216% - 235% 5%

8.2.4. Other: None

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))

Through outreach activities and the public hearing process.

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

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3. ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

Families will report to the Department when they have reached their co-payment cap. The Income Support worker will enter this information into the system, which will generate both a notice to the client that they have met the cap and it will update the AVRS system and the MMIS to reflect a no co-pay status.

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)

This information is hard coded on the eligibility file utilized by AVRS system and implanted on the Medicaid Swipe card utilized by the Native American family or individual. Pamphlets and outreach materials will also indicate this exception.

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))

Under Salud! the provider may notify the MCO that co-payments are not being made. The provider has the right to request that the enrollee be assigned to a different provider. The provider may not deny services, but may request that the enrollee be re-assigned.

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, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing

category as appropriate. (42CFR 457.570(b))

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

8.8. The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, 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 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))
The following strategic objectives and performance goals apply to New Mexico's Title XXI program:

- Necessary infrastructures are in place to accomplish outreach and presumptive eligibility processes.
- Previously uninsured children from birth through 18 years of age will have access to quality health care.
- Health care coverage will be expanded to previously uninsured children up to 235% of poverty.

Previously uninsured children from birth through 18 years of age enrolled in Medicaid will have a continuity of care in New Mexico's managed care program through a twelve months continuous eligibility policy.

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

Performance Goal for Objective 1:

By April 1999, 75% of all permissible designated agencies and providers who have applied for presumptive eligibility provider status will be trained and in place to perform outreach, presumptive eligibility and Medicaid On Site application Assistance (MOSAA) activities.

Performance Goal for Objective 2:

As of September 30, 1999, 25% of children birth through 18 years of age who are enrolled in Medicaid will have received their EPSDT screens within the periodicity schedule.

Performance Goal for Objective 3:

By October 1, 1998 a proposed plan will have been developed to expand health care coverage to uninsured children up to 235% of poverty.

Performance Goal for Objective 4:

By September 30, 1999, 45% of children eligible and currently not enrolled birth through 18 years of age will be enrolled in Medicaid.

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))

Under the Title XXI expansion to 235% of the federal poverty level, children birth through 18 years of age will have access to the same benefits currently available to current Medicaid eligible children. Most services are provided through New Mexico's managed care program, Salud!, while some specialized services are on a fee for service basis. Evaluation of services in both systems is conducted by quality assurance mechanisms conducted, or with oversight, by the Medical Assistance Division.

Those same mechanisms will be used to evaluate the delivery of services to children between 186% -235% of the FPL brought into Medicaid under Title XXI. Data collection and analysis required under the Title XIX program will apply to children brought into Medicaid by Title XXI.

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

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☒ The reduction in the percentage of uninsured children.

9.3.3. ☒ The increase in the percentage of children with a usual source of care.

9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. ☐ Immunizations
- 9.3.7.2. ☐ Well childcare
- 9.3.7.3. ☐ Adolescent well visits
- 9.3.7.4. ☐ Satisfaction with care
- 9.3.7.5. ☐ Mental health
- 9.3.7.6. ☐ Dental care
- 9.3.7.7. ☐ Other, 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)

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)

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

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

In accordance with New Mexico's approved 1915(b) Freedom of Choice Managed Care waiver, required assessment and evaluation tools and processes are in place. These same tools and processes will be utilized for Title XXI. The Medical Assistance Division's External Quality Review Organization contractor for the Waiver, IPRO, will conduct the assessment and evaluation.

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))

New Mexico has involved the public in the development of the state's CHIP plan at a number of levels.

Since October, 1998, state and federal agencies have met to discuss the CHIP program. Included in these meetings are representatives from the Human Services Department, Department of Health, Indian Health Services, Department of Insurance, School Health Program, and Children, Youth and Families Department. These same agencies have met with the new Mexico Pediatric Society which has been developing a recommended plan of action for CHIP.

New Mexico Legislators have been part of the interagency working groups. In addition, various committees of the New Mexico Legislature have held hearings on CHIP. During the 1998 Legislative Session, a bill was passed and signed into law establishing a CHIP program for New Mexico. The bill established an oversight committee for implementation of the CHIP program which will work with the interagency advisory panel.

On October 16, 1998, a public hearing was held to provide an overview of the planning process and to allow for public comment on the program design. Once the proposed Medicaid policies are issued, there will be a 30-day comment period and a public hearing.

The Medicaid Advisory Committee has been provided with CHIP updates and asked for input at each of their monthly meetings since October, 1998.

In late April, the Human Services Department, the Department of Health, and the Children, Youth and Families Department did a presentation on CHIP for 400 public school personnel involved in school health programs.

The Human Services Department issued a special CHIP edition of the SALUD! Newsletter in October to the hundreds of interested parties on the Department's mailing list. There have also been numerous television and newspaper segments on CHIP.

Public involvement will continue during the implementation of CHIP through the legislative oversight process, Medicaid policy promulgation process and through our greatly enhanced outreach efforts. Information about CHIP will also be placed on the Medicaid website: http://www.state.nm.us/hsd/mad.html.

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))

The Medical Assistance Division American Indian/Tribal Liaison is responsible for coordinating consultation activities with the Tribal

leaders and interacting with tribal organizations and the Indian Health Service. The Tribal Liaison coordinates and participates in individual meetings with Tribal leaders and staff, tribal organizations, and/or the Indian Health Service to provide updates and receive feedback on policy changes. Individual letters to Tribal leaders from the Medical Assistance Division may also be sent to highlight policy changes specific to American Indian constituents. A consultation meeting may also be coordinated with all Tribal leaders to discuss policy changes and to receive input. Tribal leaders, tribal organizations, and the Indian Health Service are included in the mailing lists for the Medicaid newsletter and Human Services Department Register Notices.

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).

Prior public notice was given with the issuance of New Mexico Human Services Register Vol. 21, No. 46 issued October 5, 1998. Public Hearing was held to receive testimony on these proposed regulations, November 19, 1998.

Final regulations were published, January 29, 1999, in Vol. 22, No. 4, of the New Mexico Human Services Register.

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.

	Eligibles	Expenditures
FEDERAL FISCAL YEAR 1998 (2 months)	1,689	
Client Services Expenditures		$307,000
Admin. Expenditures (10% of Svc. Exps.)		$30,700
Total Expenditures		$337,700
Total Method of Finance		
Federal Funds (80.83%)		$272,963
State Matching from General Fund (19.17%)		$64,737
FEDERAL FISCAL YEAR 1999		4,417
(Growth of 2,728 over FFY98, full 12 months)		
Client Services Expenditures		$4,237,000
Admin. Expenditures (10% of Svc. Exps.)		$423,700
Total Expenditures		$4,660,700
Total Method of Finance		
Federal Funds (81.09%)		$3,779,362
State Matching from General Fund (18.91%)		$881,338

Based on 8/1/98 implementation date and phase-in. Estimates based upon uninsured children only. Presumptive eligibility, 12 mo. Guarantee, & simplified application are being implemented independently.

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.

12.1. Eligibility and Enrollment Matters

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

12.2. Health Services Matters

Please describe the review process for health services matters that comply with 42 CFR 457.1120.

12.3. Premium Assistance Programs

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