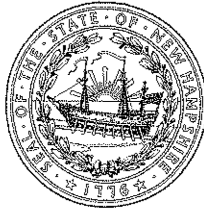

JEFFRY A. PATTISON
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(603) 271-3161

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(603) 271-3161

State of New Hampshire

OFFICE OF LEGISLATIVE BUDGET ASSISTANT
State House, Room 102
Concord, New Hampshire 03301

RICHARD J. MAHONEY, CPA
Director, Audit Division
(603) 271-2785

May 14, 2014

To the Members of the Fiscal Committee
of the General Court

The Chairman of the Fiscal Committee of the General Court, as established by RSA 14:30-a, of which you are a member, has requested that you be notified that the Fiscal Committee will hold a special meeting pertaining to, Laws of 2014, Chapter 3 (SB 413), An act relative to health insurance coverage, on **Thursday, May 22, 2014, at 1:00 p.m.** in Room 210-211 of the Legislative Office Building.

Please find attached information to be discussed at that meeting.

Sincerely,

Jeffry A. Pattison
Legislative Budget Assistant

JAP/pe
Attachments

FISCAL COMMITTEE
SPECIAL AGENDA

Thursday, May 22, 2014 in Room 210-211 of the Legislative Office Building

1:00 p.m.

(1) Acceptance of Minutes of the April 18, 2014 special meeting

(2) Chapter 3 (SB 413), Laws of 2014, New Hampshire Health Protection Act:

FIS 14-071 Department of Health and Human Services – requests approval of four (4) amendments; Alternative Benefit Plan Amendment, Cost Sharing Amendment, Payment Amendment, and FMAP Drawdown Amendment, to the New Hampshire State Medicaid Plan in order to implement the mandatory Health Insurance Premium and Voluntary Bridge to Marketplace programs under the New Hampshire Health Protection Program for the new adult group in New Hampshire, and further approval of the Section 1115 Medicaid waiver for submission to the Centers for Medicare and Medicaid Services (CMS) **[This item is currently in draft form. The item will be replaced with the final version when it is available. The final version will contain the word "Replacement" below the "FIS" item number.]**

(3) Chapter 3:7, II, Laws of 2014, Department of Health and Human Services; Contracting; Transfer Among Accounts, and RSA 14:30-a, VI Fiscal Committee Approval Required for Acceptance and Expenditure of Funds Over $100,000 from any Non-State Source:

FIS 14-067 Department of Health and Human Services – request approval to transfer $484,424 in general funds and increase related federal revenues by $118,057 and increase related other revenues by $331,490 through June 30, 2014

FIS 14-068 Department of Health and Human Services – request approval to transfer $4,456,546 in general funds and increase related federal revenues by $17,596,555 and decrease related other revenues by ($785,531) through June 30, 2014

(4) Date of Next Meeting and Adjournment

The next regular meeting of the Fiscal Committee is scheduled for Monday, June 9, 2014 at 10:00 a.m.

FISCAL COMMITTEE OF THE GENERAL COURT
MINUTES
April 18, 2014

The Fiscal Committee of the General Court met on Friday, April 18, 2014 at 9:00 a.m. in Room 210-211 of the Legislative Office Building.

Members in attendance were as follows:

Representative Ken Weyler, Clerk
Representative Cindy Rosenwald
Representative Peter Leishman
Representative Daniel Eaton
Representative Bernard Benn (Alternate)
Senator Jeanie Forrester, Vice Chair
Senate President Chuck Morse
Senator Bob Odell
Senator Sylvia Larsen
Senator Andy Sanborn

Vice Chairman Forrester opened the meeting at 9:03 a.m.

NEW BUSINESS:

CHAPTER 3 (SB 413), LAWS OF 2014, NEW HAMPSHIRE HEALTH PROTECTION ACT:

FIS 14-063 Replacement Department of Health and Human Services – Jeffrey Meyers, Director of Intergovernmental Affairs, Department of Health and Human Services presented the request and responded to questions of the Committee.

On a motion by Representative Eaton, seconded by Representative Rosenwald, that the Committee approve the request of the Department of Health and Human Services for approval of an amendment to the New Hampshire State Medicaid Plan in order to add the new adult group ("newly eligible adults") for coverage in New Hampshire. MOTION ADOPTED. (8-Yes, 2-No)

The Committee recessed at 9:16 a.m. and reconvened at 9:28 a.m.

CHAPTER 3:7, II, LAWS OF 2014, DEPARTMENT OF HEALTH AND HUMAN SERVICES; CONTRACTING; TRANSFER AMONG ACCOUNTS, AND RSA 14:30-a, VI FISCAL COMMITTEE APPROVAL REQUIRED FOR ACCEPTANCE AND EXPENDITURE OF FUNDS OVER $100,000 FROM ANY NON-STATE SOURCE:

FIS 14-064 Department of Health and Human Services – Nicholas Toumpas, Commissioner, Department of Health and Human Services presented the request and responded to questions of the Committee.

On a motion by Representative Eaton, seconded by Representative Rosenwald, that the Committee approve the request of the Department of Health and Human Services to transfer $2,397,864 in general funds and increase related federal revenues by $10,587,042 and decrease related other revenues by ($236,326) for SFY 2014, and to transfer $1,775,415 in general funds and increase related federal revenues by $542,357 and decrease related other revenues by ($995,273) for SFY 2015, through June 30, 2015. MOTION ADOPTED. (8-Yes, 2-No)

DATE OF NEXT MEETING AND ADJOURNMENT

On a motion by Representative Rosenwald, seconded by Representative Eaton, that the meeting adjourn. (Whereupon the meeting adjourned at 9:39 a.m.)

The next regular meeting of the Fiscal Committee was previously set for Friday, April 25, 2014 at 10:00 a.m.

Representative Ken Weyler, Clerk

State of New Hampshire
DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 PLEASANT STREET, CONCORD, NH 03301-3857
XXXXXXXXXX FAX: 603-271-4912 TDD ACCESS: 1-800-735-2964
New Number: 603-271-9200

NICHOLAS A. TOUMPAS
COMMISSIONER

FIS 14 071

May 7, 2014

The Hon. Mary Jane Wallner, Chairman
Fiscal Committee of the General Court
Legislative Office Building
104 North State Street
Concord, N.H. 03301

Dear Chairman Wallner and Members of the Committee:

Requested Action

Pursuant to the requirements of the New Hampshire Health Protection Act (SB 413), codified at RSA 126-A:5,XXIII-XXVI, the New Hampshire Department of Health and Human Services requests approval of four amendments to the New Hampshire State Medicaid Plan in order to implement the mandatory Health Insurance Premium and Voluntary Bridge to Marketplace programs under the New Hampshire Health Protection Program for the new adult group in New Hampshire. These state plan amendments are:

1. Alternative Benefit Plan Amendment
2. Cost Sharing Amendment
3. Payment Amendment
4. FMAP Drawdown Amendment

The Department also requests, pursuant to Section 5 of SB 413, 2014 Laws 3:5 (codified at RSA 126-A:67), approval of the Section 1115 Medicaid waiver for submission to the Centers for Medicare and Medicaid Services (CMS).

Background and Description of SPAs and Section 1115 Waiver Application

The N.H. Department of Health and Human Services (DHHS) is submitting the remaining Medicaid state plan amendments and draft Section 1115 Medicaid Waiver Application to the Fiscal Committee for review and approval at the May 22, 2014 meeting.

Specifically, we are submitting the state plan amendments for (i) the Alternative Benefit Plan (ABP), which describes in detail the benefits to be made available to the new adult group under the New Hampshire Health Protection Program (NHHPP); (ii) the cost sharing requirements for the mandatory HIPP and Voluntary Bridge to Marketplace Programs; and (iii) the payment of the 100% FMAP for the new adult group through December 31, 2016, consistent with the requirements of the NHHPP. As part of the ABP SPA, we are submitting changes to the Medicaid state plan "payment pages" in order to authorize federal payment of the new

Substance Use Disorder Benefit for the new adult group, which is a new benefit that is being authorized for federal payment for the first time.

Also enclosed is a copy of the Department's application for a Medicaid waiver under Section 1115 of the Social Security Act that has been posted for public comment until May 20, 2014 and for public hearing on May 8th and May 12th.

The state plan amendments and the waiver application are being submitted in draft. The ABP SPA and the Cost Sharing SPA have been noticed for public comment, and the public comment period does not end until May 21st. CMS is aware that the SPAs will be subject to action by Fiscal on May 22nd, and we are working as quickly as possible to finalize the SPAs in order that final versions can be presented to Fiscal on May 22nd.

We do not anticipate significant changes from the drafts that are being submitted today. At the May 22nd meeting, we will be prepared to highlight any and all changes that have been made to the SPAs.

The enclosed waiver application is the version that has been released for public comment and public hearing. The public hearings are scheduled for May 8th and May 12th, and the public comment period remains open until the close of business on May 20th. Once the Department receives all public comment and testimony on the waiver through May 20th, the waiver application can be finalized and submitted to Fiscal. The Department will be prepared to highlight any changes to the waiver application that resulted from the public comment and public hearings at the May 22nd meeting.

For the Committee's information, we have summarized below the contents and purpose of the state plan amendments.

1. Alternative Benefit Plan SPA

The Alternative Benefit Plan is the plan established by the state for the medical benefits provided to the new adult group. Under federal law, the ABP must cover the 10 essential health benefits, early periodic screening diagnostic and treatment services for 19 and 20 year olds; and non-emergency medical transportation. In recognition of the requirements of the New Hampshire Health Protection Program to eventually transition most of the new adult group to Qualified Health Plans on the New Hampshire Marketplace, the Department is aligning its ABP with existing QHPs on the Marketplace.

The ABP SPA is made up of 11 separate sections, as follows:

ABP 1: This section identifies (i) the population for which the ABP is being established – the new adult group; (ii) that enrollment is mandatory, and (iii) that the new adult population will be state wide.

ABP 2a: This section documents how the ABP will be applied to the new adult group. It establishes that New Hampshire's ABP will not offer all of the benefits provided by the standard state Medicaid benefit. (As pointed out above, we are aligning the ABP with the

Essential Health Benefits in the "Benchmark" plan for New Hampshire, which is the Mathew Thornton Blue Health Plan). This section also contains series of boxes that contain a "check." These are federal requirements with which we must comply.

Page 2 of ABP 2a also contains a narrative that explains how New Hampshire will identify and provide benefits to those individuals who are "medically frail."

Federal law requires that individuals who have a physical, mental or emotional health condition that causes limitations in daily activities such as bathing, dressing, daily chores or who live in a medical facility or nursing home must be offered the choice of receiving the state's current Medicaid benefit, as opposed to the ABP. These persons are considered 'medically frail," and, as such, must be given the opportunity to access services not included in the ABP such as long term care services, provided that they also satisfy the medical necessity requirements for those services.

ABP2c: This section is very similar to ABP 2a. ABP2c documents assurances that will be provided to those newly eligible persons that are exempt from mandatory enrollment such as children, currently eligible parents, blind or disables persons, pregnant women and foster children.

The boxes checked in ABP2c are federal requirements. The boxes that contain an "x" indicate how the state will comply with certain requirements. For example, on page 1 of 3 of ABP2c, we have indicated that we will identify exempt individuals by reviewing eligibility criteria and through self-identification.

ABP3: This section documents the coverage that will be offered to the newly eligible population: the essential health benefits as established under the Mathew Thornton Blue Plan, plus the essential health benefits that are not included in that plan, namely, non-emergency medical transportation, Early Periodic Screening, Diagnosis and Treatment Services (EPSDT) for 19 and 20 year olds, and access to federally qualified health centers, rural health centers and family planning providers.

ABP4: This section references the cost-sharing plan that is being submitted for the new adult population. There is a separate SPA for cost-sharing that is being submitted to the Fiscal Committee. The contents of the cost-sharing proposal are described below in that section of the letter.

ABP5: The purpose of this section is to describe the benchmark plan that is used to establish the ABP in New Hampshire. The benchmark plan is the Mathew Thornton Blue plan, and also includes oral and vision benefits as established under a federal benefits plan called the FEDVIP plan.

This section also lists the benefits to be provided, along with information regarding prior authorization, service limits, and scope of coverage limits, if any.

ABP7: The purpose of this section is to obtain state assurances for the provision of EPSDT services to 19 and 20 year olds in the new adult group.

ABP8: The purpose of this section is to establish that managed care will be used to deliver services to the new adult group.

ABP9: This section documents that New Hampshire will be providing the ABP to those newly eligible persons with access to cost effective employer sponsored insurance. To the extent that the employer insurance does not provide an essential health benefit included in the ABP, such benefit will be provided to the newly eligible person through a wrap of benefits. This same provision is made for any newly eligible that accesses coverage though a voluntary premium assistance program, if determined to be cost effective.

ABP10: This section reflects several general assurances regarding the ABP as required by federal law such as compliance with existing law, non-discrimination provisions and the federal Medicaid statute.

ABP11: This section documents that for any benefit provided under the ABP that is not provided through managed care, the state will use a state plan approved payment methodology.

Please note there is no ABP2b or ABP6. Those sections do not apply to the ABP being submitted by the state.

2. Payment SPA

Included with the Alternative Benefit SPA are changes to the payment provisions of New Hampshire's state Medicaid plan that will authorize the payment by Medicaid of certain services required under federal law for the new adult group that the state does not now provide to the current population. These new services are the substance use disorder benefit and chiropractic services, which are included under the Essential Health Benefits. These Medicaid state plan "payment pages" must be amended to include these two categories of benefits so that services rendered for the new adult group will be paid by the federal government. These services will be paid with 100% federal funds through December 31, 2016.

Because the payment pages are changes to the New Hampshire state Medicaid plan, they are considered a state plan amendment that must be approved by the Fiscal Committee in accordance with the New Hampshire Health Protection Act.

3. Cost-Sharing SPA

The Cost Sharing SPA describes the charges and co-payments that will be applied to the new adult group consistent with the New Hampshire Health Protection Act. The language of SB 413 provides that:

> "To the greatest extent practicable the waiver or state plan amendments shall incorporate measures to promote continuity of health insurance coverage and

> personal responsibility, including but not limited to: co-pays, deductibles, disincentives for inappropriate emergency room use, and mandatory wellness programs. "

SB 413, 2014 Laws Ch. 3:2 XXIV(b).

In summary, the Department is proposing the following cost-sharing provisions:

1. The new adult group with incomes above 100% of the FPL will be subject to a prescription drug co-pay of $1 for generic prescription drugs and $4 for brand prescription drugs.
2. Those in the Ticket to Work Program (MEAD) above 100% of the FPL would remain subject to the current prescription drug co-pays of $1 for generic prescription drugs and $2 for brand prescription drugs.
3. The new adults with incomes under 100% of the FPL and the existing Medicaid beneficiaries who are under 100% of the FPL would not be subject to any co-pays.
4. The new adults with incomes over 100% of the FPL would also be subject to an $8 dollar fee for the inappropriate use of the Emergency Room.

Like the ABP SPA, the Cost Sharing SPA is comprised of several sections, as follows:

G1: This section documents that the state will comply with federal law in applying cost sharing to persons who are Medicaid beneficiaries. The boxes that contain a "check" are federal requirements, as are the boxes that are shaded in black. The boxes shaded in black appear automatically on the form (which is electronic) once the check is made at the beginning of a section. The boxes that contain an "x" reflect how the state will comply with a particular requirement.

On page 2 of G1, the SPA contains a narrative description of how a medical provider will determine whether emergency department services are medically necessary, a description of the requirement for alternative treatment options for non-emergent care and the definition of a an emergency medical condition.

G2a: This section affirms that the state does not charge cost sharing to those persons who are considered to be categorically needy of Medicaid coverage such as children, pregnant women, newborns, persons receiving SSI, the blind and disabled and those who are dual eligible. This SPA would not be approvable if we indicated that we apply cost sharing to the categorically needy.

G2b: This section affirms that the state does not charge cost sharing to those who are considered "medically needy," who are the population that are not eligible because of income, but would be eligible for Medicaid if they spent their excess income on medical bills, i.e. the "spend down population."

G2c: This section describes the cost sharing being applied to the new adult group in the New Hampshire Health Protection Program that is outlined above.

G3: This section documents how the state will comply with a variety of federal requirements for the imposition of cost sharing.

4. FMAP SPA

New Hampshire is also submitting an FMAP claiming SPA that will allow the state to claim the 100% federal funds for the new adult group for the period through December 31, 2016. The FMAP SPA identifies the population and the methodology used by the State to claim the federal funds to pay for all medical services for the new adult group.

5. Section 1115 Waiver Application

The Department is also submitting the draft application for a Medicaid waiver under Section 1115 of the Social Security Act. The version of the application that is enclosed is that which was posted for public comment on April 21, 2014. As noted above, the final version of the application will be presented to the Fiscal Committee on May 22, 2014 following the close of the public comment period. _The draft application is consistent with the PowerPoint presentation by the Department to the Fiscal Committee on April 25th.

We look forward to meeting with the Committee on May 22nd to present the SPAs and Section 1115 waiver application to you.

Approved:

Nicholas A. Toumpas
Commissioner

Jeffrey A. Meyers
Director, Intergovernmental Affairs

Enclosures
cc: Members, Fiscal Committee

Alternative Benefit Plan

Attachment 3.1-L-

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: New Hampshire New Adult Group

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20131219

Alternative Benefit Plan

Attachment 3.1-L- [ ]

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act **ABP2a**

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan. No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☒ Other

Alternative Benefit Plan

Describe:

The State gives beneficiaries the option of receiving all official communications through an online portal, rather than a paper notice. Individuals who elect this option receive an email notifying them that a new notice has been uploaded to the portal. When the individuals log on to the portal, they see a PDF of a notice. The text of the notice is identical to the hard copy notice sent to other individuals.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

During the application process, if a member answers "yes" to the following question: "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?" it will trigger a "Medical Frailty Notice" along with the Medicaid eligibility determination notice informing them they have a right to choose between the Alternative Benefit Plan (ABP) and the ABP that is the Medicaid State Plan and informing them of the differences in the benefits.

Every enrollee will receive a copy of their Rights and Responsibilities including information about medical frailty and how to get more information regarding their coverage options. A copy of this document is also provided to every member at the time of their annual redetermination or in the event they have an eligibility category change.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

During the application process, if a member answers "yes" to the following question: "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?" it will trigger a "Medical Frailty Notice" along with the Medicaid eligibility determination notice informing them they have a right to choose between the Alternative Benefit Plan (ABP) and the ABP that is the Medicaid State Plan and informing them of the differences in the benefits.

Every enrollee will receive a copy of their Rights and Responsibilities including information about medical frailty and how to get more information regarding their coverage options. A copy of this document is also provided to every member at the time of their annual redetermination or in the event they have an eligibility category change.

Additionally, a Medicaid member can self-identify at any time as having a chronic substance use disorder, serious and complex medical condition, or physical, behavioral, intellectual, or developmental disorder and can discuss coverage options with their doctor, contact Member Services or visit the Medicaid website for additional information.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

☒ In the eligibility system.

Alternative Benefit Plan

☐ In the hard copy of the case record.

☐ Other

What documentation will be maintained in the eligibility file? (Check all that apply)

☒ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☐ Other

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20131219

Alternative Benefit Plan

Attachment 3.1-L- ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Enrollment Assurances - Mandatory Participants **ABP2c**

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

The state will review to ensure the person is newly eligible under Section 1902(a)(10)(A)(i)(VIII) and is not in any of the following categories: children; currently eligible parents; blind or disabled; pregnant women; or foster children.

☒ Self-identification

Describe:

During the application process, if a member answers "yes" to the following question: "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?" it will trigger a "Medical Frailty Notice" along with the Medicaid eligibility determination notice informing them they have a right to choose between the Alternative Benefit Plan (ABP) and the ABP that is the Medicaid State Plan.

Every enrollee will receive a copy of their Rights and Responsibilities including information about medical frailty and how to get more information regarding their coverage options. A copy of this document is also provided to every member at the time of their annual redetermination or in the event they have an eligibility category change.

Additionally, a Medicaid member can self-identify at any time during their eligibility period as having a chronic substance use disorder, serious and complex medical condition, or physical, behavioral, intellectual, or developmental disorder and can discuss coverage options with their doctor, contact Member Services or visit the Medicaid website for additional information. Member Services staff will have a script for providing choice counseling to people who identify themselves as medically frail.

☐ Other

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Alternative Benefit Plan

☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

☐ Review of claims data

☒ Self-identification

☒ Review at the time of eligibility redetermination

☐ Provider identification

☒ Change in eligibility group

☐ Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

○ Monthly

○ Quarterly

○ Annually

◉ Ad hoc basis

○ Other

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

Individuals who self-identify as medically frail at the time of application will return the notice included with their eligibility determination in order to notify the State that they would like to be disenrolled from the ABP and enrolled in the ABP that is the Medicaid State Plan. Instructions for completing this process are included in their eligibility determination notice.

Individuals seeking exemption from the Alternative Benefit Plan at any time during their period of eligibility will notify the Medicaid agency who will initiate the change process. The appropriate contact information for the agency is included in their eligibility determination notice. Once the applicant makes the request, the same notice delivered as part of the medically frail individuals' eligibility notice will be sent to the member. Individuals that would like to be enrolled in the ABP that is the Medicaid State Plan must complete the form and return it to the Medicaid agency to complete the process. All requests to disenroll from the ABP must be submitted in writing to the Medicaid agency.

The notices provided to individuals who either respond affirmatively to the triggering question on the initial application or who later self-identify as exempt include a description of the differences between the ABP and the ABP that is the Medicaid State Plan. The notices also inform individuals that if they elect to receive the ABP, they may request to be moved to the ABP that is the Medicaid State

Alternative Benefit Plan

Plan at any time by contacting the Medicaid agency.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

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Attachment 3.1-L- ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

○ The state/territory is amending one existing benefit package for the population defined in Section 1.

◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Adult Group Alternative Benefit Package

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

◉ Benchmark Benefit Package.

○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).

○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):

○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):

◉ Secretary-Approved Coverage.

○ The state/territory offers benefits based on the approved state plan.

◉ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

New Hampshire has created its Adult Group Alternative Benefit Package based on the Matthew Thornton Blue Health Plan, which is the base benchmark plan selected by the State to define Essential Health Benefits for products in the Marketplace. The State has added the additional benefits required for the Alternative Benefit Package, but not covered by the base benchmark plan, namely, non-emergency medical transportation and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Individuals will also have access to FQHC and RHC services, as well as open access to family planning providers.

The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Alternative Benefit Plan

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- (●) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: Matthew Thornton Blue Health Plan

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The Matthew Thornton Blue Health Plan is the second largest plan by enrollment in the small group insurance market. The Matthew Thornton Blue Health Plan was selected by the State of New Hampshire to be the base benchmark plan to define essential health benefits for the individual and small group markets in New Hampshire.

PRA Disclosure Statement

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Attachment 3.1-L- ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Alternative Benefit Plan Cost-Sharing **ABP4**

☐ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. Yes

☑ The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

The State will submit State Plan Amendments eliminating cost-sharing for all individuals with incomes less than or equal to 100% FPL. The State will submit State Plan Amendments to impose targeted cost-sharing on individuals in the new adult group with incomes above 100% FPL. The cost-sharing described in that State Plan Amendment will apply to all individuals in the new adult group with incomes above 100% FPL, regardless of whether they are receiving the Alternative Benefit Plan or the Alternative Benefit Plan that is the Medicaid State Plan.

PRA Disclosure Statement

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Alternative Benefit Plan

Attachment 3.1-L- ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Benefits Description **ABP5**

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

The base benchmark plan is the Matthew Thornton Blue Health Plan, supplemented with FEDVIP pediatric oral and vision benefits.

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary Approved

Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services — Collapse All

Benefit Provided: Primary Care Visit to Treat an Injury of Illness
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Specialist Visit
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Other Practitioner Office Visit (APRN, PA, etc.)
Source: Base Benchmark Small Group

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes Advance Practice Registered Nurse, Physician Assistant, Nurse Practitioner, and Certified Midwives, consistent with their scope of practice.

Remove

Benefit Provided: Outpatient Facility Fee (e.g., Amb. Surgery Ctr.)

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Excludes coverage for reversal of voluntary sterilization; schlerotherapy for varicose veins and treatment of spider veins; sex change treatment; and corrective eye surgery.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Outpatient Surgery Physician/Surgical Services

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Excludes coverage for reversal of voluntary sterilization; schlerotherapy for varicose veins and treatment of spider veins; sex change treatment; and corrective eye surgery.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization required for the following surgical services: bariatric surgery, breast reduction, blepharoplasty, panniculectomy, septoplasty, and rhinoplasty.

Benefit Provided: Hospice Services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

2. Essential Health Benefit: Emergency services — Collapse All

Benefit Provided: Urgent Care Centers or Facilities

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Emergency Room Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Emergency Transportation/Ambulance

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Add

Alternative Benefit Plan

3. Essential Health Benefit: Hospitalization

Collapse All

Benefit Provided: Inpatient Hospital Services

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Excludes coverage for reversal of voluntary sterilization; schlerotherapy for varicose veins and treatment of spider veins; sex change treatment; and corrective eye surgery.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization is required only for out-of-state inpatient hospitalization.

Benefit Provided: Inpatient Physician and Surgical Services

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization required for the following surgical services: bariatric surgery, breast reduction, blepharoplasty, panniculectomy, septoplasty, and rhinoplasty.

Benefit Provided: Bariatric Surgery

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided:	Source:
Transplant	Base Benchmark Small Group
Authorization:	Provider Qualifications:
Prior Authorization	State Plan & Public Employee/Commercial Plan
Amount Limit:	Duration Limit:
None	None
Scope Limit:	
None	

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization is required for all organ transplants, except kidney transplants.

Add

Alternative Benefit Plan

4. Essential Health Benefit: Maternity and newborn care

Collapse All

Benefit Provided: Prenatal and Postnatal Care

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Delivery and All Inpatient Services for Maternity

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Minimum stay of 48 hours

Add

Alternative Benefit Plan

5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Collapse All

Benefit Provided: Mental/behavioral Health Outpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: See below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits are available for outpatient treatment for mental health care and substance abuse care, partial hospitalizations, and day/night visits.
No benefits are available for therapy, counseling or any non-surgical inpatient or outpatient service, care or program to treat obesity or for weight control; custodial care, convenience services, milieu therapy, marriage or couples counseling; therapy for sexual dysfunctions; recreational or play therapy; educational evaluation; career counseling; services for nicotine withdrawal or dependence; psychoanalysis; telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider; and care extending beyond short-term therapy for detoxification and/or rehabilitation for a substance abuse condition in an outpatient/office setting.

Benefit Provided: Mental/behavioral health inpatient services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: See below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits are available for inpatient hospital services or residential treatment center facility for mental health care; inpatient rehabilitation treatment for substance abuse care in a hospital or substance abuse treatment facility; partial hospitalizations; and day/night visits.
No benefits are available for therapy, counseling or any non-surgical inpatient or outpatient service, care or program to treat obesity or for weight control; custodial care, convenience services, milieu therapy, marriage or couples counseling; therapy for sexual dysfunctions; recreational or play therapy; educational evaluation; career counseling; services for nicotine withdrawal or dependence; psychoanalysis; telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and

Alternative Benefit Plan

the provider; and inpatient care for medical detoxification extending beyond the acute detoxification phase of a substance abuse condition.
Benefits exclude IMDs.

Remove

Benefit Provided: Substance Abuse Disorder Outpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: See below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits are available for outpatient treatment for mental health care and substance abuse care, partial hospitalizations, and day/night visits.
No benefits are available for therapy, counseling or any non-surgical inpatient or outpatient service, care or program to treat obesity or for weight control; custodial care, convenience services, milieu therapy, marriage or couples counseling; therapy for sexual dysfunctions; recreational or play therapy; educational evaluation; career counseling; services for nicotine withdrawal or dependence; psychoanalysis; telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider; and care extending beyond short-term therapy for detoxification and/or rehabilitation for a substance abuse condition in an outpatient/office setting.

Benefit Provided: Substance Abuse Disorder Inpatient Services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: See below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits are available for inpatient hospital services or residential treatment center facility for mental health care; inpatient rehabilitation treatment for substance abuse care in a hospital or substance abuse treatment facility; partial hospitalizations; and day/night visits.
No benefits are available for therapy, counseling or any non-surgical inpatient or outpatient service, care or program to treat obesity or for weight control; custodial care, convenience services, milieu therapy, marriage or couples counseling; therapy for sexual dysfunctions; recreational or play therapy; educational evaluation; career counseling; services for nicotine withdrawal or dependence; psychoanalysis; telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and

the provider; and inpatient care for medical detoxification extending beyond the acute detoxification phase of a substance abuse condition.
Benefit excludes IMDs.

Remove

Add

Alternative Benefit Plan

■ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):

- ☐ Limit on days supply
- ☐ Limit on number of prescriptions
- ☐ Limit on brand drugs
- ☐ Other coverage limits
- ☒ Preferred drug list

Authorization: Yes

Provider Qualifications: State licensed

Coverage that exceeds the minimum requirements or other:

The State of New Hampshire's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs.

Alternative Benefit Plan

7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All

Benefit Provided: Home Health Care Services
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Scope Limit: No benefits are available for custodial care.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Skilled Nursing Facility
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: 100 days per year
Duration Limit: None

Scope Limit: No benefits are available for custodial care.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Outpatient Rehabilitation Services
Source: Base Benchmark Small Group

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: 20 visits per year for each therapy type
Duration Limit: None.

Scope Limit: See below.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

There is a separate 20 visit limit for each of the following types of therapies: physical therapy, occupational therapy, and speech therapy. Benefit limits are shared between outpatient rehabilitation and habilitation services.

No benefits are available for on-going or life-long exercise and education programs intended to maintain lifelong physical fitness; voice therapy or vocal retraining; preventive therapy or therapy provided in a group setting; therapy for educational reasons; therapy for sport, recreational, or occupational reasons; or therapy for TMJ.

Remove

Benefit Provided: Respiratory Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Cardiac Rehabilitation

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Habilitation Services

Source: Base Benchmark Small Group

Alternative Benefit Plan

Authorization:	Provider Qualifications:
None	State Plan & Public Employee/Commercial Plan
Amount Limit:	Duration Limit:
20 visits for each therapy type	None

Remove

Scope Limit:

See below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

There is a separate 20 visit limit for each of the following types of therapies: physical therapy, occupational therapy, and speech therapy. Benefit limits are shared between outpatient rehabilitation and habilitation services.

No benefits are available for on-going or life-long exercise and education programs intended to maintain lifelong physical fitness; voice therapy or vocal retraining; preventive therapy or therapy provided in a group setting; therapy for educational reasons; therapy for sport, recreational, or occupational reasons; or therapy for TMJ.

Benefit Provided:	Source:
Chiropractic Care	Base Benchmark Small Group
Authorization:	Provider Qualifications:
None	State Plan & Public Employee/Commercial Plan
Amount Limit:	Duration Limit:
12 vistis per year	None

Remove

Scope Limit:

Includes spinal manipulation and manual medical intervention services

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:	Source:
Durable Medical Equipment	Base Benchmark Small Group
Authorization:	Provider Qualifications:
Prior Authorization	State Plan & Public Employee/Commercial Plan
Amount Limit:	Duration Limit:
None	None

Scope Limit:

None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefits are available for durable medical equipment, medical supplies, and prosthetic devices. Prior authorization is required for durable medical equipment and adult incontinence supplies.

Add

Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services

Collapse All

Benefit Provided: Diagnostic Tests (X-Ray and Lab Work)

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

No benefits are available for diagnostic x-rays in connection with research or study.

Benefit Provided: Imaging (CT/PET scans/MRIs)

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization is required for the following types of imaging: CT, PET, MRI, MRA, and nuclear cardiology.

Add

Alternative Benefit Plan

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management   Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Preventive Care/Screening/Immunization

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The preventive care benefit includes the following: (1) all services listed on the USPSTF A and B lists; (2) Advisory Committee for Immunization Practices (ACIP) recommended vaccines; (3) preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and (4) additional preventive services for women recommended by the Institute of Medicine (IOM) and HRSA. This benefit includes family planning services and contraceptive coverage, consistent with the requirements of the additional preventive services for women recommended by the IOM and HRSA. Specifically, the preventive services benefit includes all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.

Add

Alternative Benefit Plan

10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

EPSDT will apply for all 19 and 20 year olds. Prior authorization required for the following dental services: comprehensive and interceptive orthodontics, dental orthotic devices, surgical periodontal treatment, and extractions of asymptomatic teeth.

Add

Alternative Benefit Plan

☒ 11. Other Covered Benefits from Base Benchmark

Collapse All ☐

Other Base Benefit Provided:
Routine Eye Exam (Adult)

Source:
Base Benchmark

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
1 exam every 2 years

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit:
No prior authorization.

Add

Alternative Benefit Plan

☐ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication   Collapse All ☐

Alternative Benefit Plan

☐ 13. Other Base Benchmark Benefits Not Covered — Collapse All ☐

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits — Collapse All ☐

Other 1937 Benefit Provided:	Source:
Non-Emergency Medical Transportation	Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:	Provider Qualifications:
Prior Authorization	Medicaid State Plan

Amount Limit:	Duration Limit:
None	None

Scope Limit:

None

Other:

Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.

Add

Alternative Benefit Plan

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

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Attachment 3.1-L- [ ]

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

All individuals in the new adult group who receive the Alternative Benefit Plan will be enrolled in Medicaid managed care plans. The ABP benefit package administered by the plans will include coverage for EPSDT services for 19 and 20 year olds. Dental benefits for 19 and 20 year olds are not included in the Medicaid managed care plan benefit package, and these benefits will be provided through the fee-for-service Medicaid program.

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

Alternative Benefit Plan

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

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V.20131219

Alternative Benefit Plan

Attachment 3.1-L- [ ]

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Service Delivery Systems **ABP8**

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

- ☒ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☐ Prepaid Ambulatory Health Plans (PAHP).
- ☐ Primary Care Case Management (PCCM).

☒ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The State will leverage its three existing Medicaid managed care plans to administer the ABP. The State will update the contracts with the plans to reflect the new ABP benefit package, and the State will establish capitation rates for the new adult group. The State will work closely with the plans to inform them about the benefits unique to the ABP. The State will require that plans contract with additional providers, as needed, to ensure adequate access to the full range of services offered in the ABP. The State will also require that the plans notify their participating providers of the unique features of the ABP.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. No

☑ The Alternative Benefit Plan will be provided through a managed care organization (MCO) consistent with applicable managed care requirements (42 CFR Part 438, and sections 1903(m), 1932 and 1937 of the Social Security Act).

MCO Procurement or Selection Method

Indicate the method used to select MCOs:

- (●) Competitive procurement method (RFP, RFA).
- ( ) Other procurement/selection method.

Alternative Benefit Plan

Describe the method used by the state/territory to procure or select the MCOs:

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. Yes

List the benefits or services that will be provided apart from the MCO, and explain how they will be provided. Add as many rows as needed.

	Benefit/service	Description of how the benefit/service will be provided	
+	Skilled Nursing Facility	Benefit will be provided through fee-for-service Medicaid.	X
+	Inpatient Hospital Swing Bed, SNF	Benefit will be provided through fee-for-service Medicaid.	X

MCO service delivery is provided on less than a statewide basis. No

MCO Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: Yes

Select all that apply:

☒ Individuals with other medical insurance.

☐ Individuals eligible for less than three months.

☒ Individuals in a retroactive period of Medicaid eligibility.

☐ Other:

General MCO Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

◉ Mandatory participation.

○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

Enrollees who fail to make a voluntary MCO selection within the initial 60 days of the enrollment process will be auto-assigned to an MCO. Auto-assignment processes will provide for verification of paid claims data within the past 6 months on fee-for-service (if applicable), to determine a regular site of primary or specialty care (if no primary care encounters are identified) and assign the enrollee to an MCO which has a contract with the provider that the enrollee's past claims history demonstrates an existing relationship. If this process fails to identify a provider relationship, the state will determine if a household member has selected a plan already, and enroll the non-assigned member into the same plan as their household member. For beneficiaries for whom it is not possible to determine any prior patient/provider relationship or family member plan selection, the state will randomly assign members to ensure equitable enrollment among plans. All managed care enrolled individuals may disenroll from the plan they selected or were autoassigned to within 90 days of their plan enrollment, with or without cause. If after 90 days, they have not disenrolled, they will be locked into that plan for a period of 12 months. If the member disenrolls from a plan within the 90 day window and does not disenroll from managed care (if that option applies) they must select a new plan in which to enroll.

Additional Information: MCO (Optional)

Alternative Benefit Plan

Provide any additional details regarding this service delivery system (optional):

The state will amend its contracts with existing MCOs to include the full scope of ABP benefits. The state will also develop a capitation rate for the new adult group. MCOs will have the authority to develop utilization management plans, including selecting which categories of benefits are subject to prior authorization. As a result, the authorization requirements may differ from those set forth in ABP5, and they may differ across MCOs. The State will review and approve the MCO's utilization management plans. As part of that review process, the State will ensure that the prior authorization requirements imposed do not violate mental health parity requirements.

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

(●) Traditional state-managed fee-for-service

( ) Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Some long-term care benefits are not included in the MCO's benefit package currently; instead, the State provides these services through a separate fee-for-service process. To the extent the benefits that are not currently covered by the MCO benefit packages are included in the ABP, the State will cover those benefits through the fee-for-service system.

Additionally, individuals will receive the ABP through fee-for-service while they are awaiting enrollment in an MCO.

All benefits provided through the fee-for-service system will be subject to the authorization requirements set forth in ABP5.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

Procurement Methodology (Text Box Above Not Working): The state will leverage the three existing MCOs that are serving the currently eligible Medicaid population. The state used a competitive bid RFP process to identify those contractors. The technical scoring of the RFP bids consisted of an interdepartmental team of 10 members who read each proposal and scored them based on 11 domains, including, but not limited to pharmacy, care coordination, disease management, quality, member services, administration, behavioral health. Each team member scored each plan and then the team came together for consensus building to assign a score (maximum of 1100) to each plan. The three highest scoring plans were selected.

PRA Disclosure Statement

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V.20131219

Alternative Benefit Plan

Attachment 3.1-L- ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. **Yes**

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

All newly eligible individuals with access to cost-effective employer-sponsored insurance will be required to receive coverage through the State's Health Insurance Premium Payment (HIPP) program. The state assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

The state/territory otherwise provides for payment of premiums. **Yes**

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

Newly eligible individuals will be permitted to voluntarily enroll in cost-effective individual market coverage consistent with updated State Plan Amendments that the state will submit separately. For a Medicaid beneficiary who receives coverage in a health plan in the individual market through the state's approved Medicaid state plan that provides premium assistance under section 1905(a) and regulations codified at 42 CFR §435.1015, the state assures that the Medicaid beneficiary will receive a benefit package that includes a wrap of benefits around the individual market health plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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V.20131219

Alternative Benefit Plan

Attachment 3.1-L- [ ]

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/ territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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V.20131219

Alternative Benefit Plan

Attachment 3.1-L- ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Payment Methodology — ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

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V.20131219

DRAFT

ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

1. Chiropractor Services – Payment for chiropractor services provided under New Hampshire's alternative benefit plan is made in the same manner as for state plan services for "other licensed practitioners." Payment is made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of July 1, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

2. Services for the Treatment of Substance Use Disorders – New Hampshire's Medicaid state plan specifies the reimbursement methodology in Attachment 4.19-A and Attachment 4.19-B for some services that are rendered for the treatment of substance use disorders. Please refer to the appropriate, existing Attachments for these services as follows:

   Attachment 4.19-A – Inpatient Hospital Reimbursement
   - Inpatient Hospital Acute Care Services for Substance Use Disorders
   - Inpatient Governmental Psychiatric Hospital

   Attachment 4.19-B – Payment for All Types of Care Other Than Inpatient Hospital, Skilled Nursing, or Intermediate Nursing Care Services
   - Outpatient Hospital Services
   - Physician Services
   - Services of Other Licensed Practitioners
   - Clinic Services
   - EPSDT
   - Prescribed Drugs
   - Extended Services to Pregnant Women

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ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

2. Services for Treatment of Substance Use Disorders (continued)

The reimbursement methodology for other services in the alternative benefit plan, that are not already in the state plan for the current eligibles, for treatment of substance use disorders are as described below:

(a) Services of Other Licensed Practitioners – Payment for all types of other licensed practitioners who are not included above is made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. The department's rates were set as of July 1, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

(b) Outpatient Services Facilities – Payment for services provided by outpatient facilities are as described below.

(1) Intensive Outpatient Services: Payment for intensive outpatient services provided by outpatient facilities shall be made at a per diem rate as established by the department pursuant to NH RSA 161:4, VI. The per diem rate was established based on the department's current per diem rate for a similar service (H0035 – ½ day partial hospitalization).

(2) Partial hospitalization: Payment for partial hospitalization provided in an outpatient services facility shall be made at a per diem rate as established by the department pursuant to NH RSA 161:4, VI. The per diem rate was established based on the department's current per diem rate for a similar service (S0201).

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ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

2. Services for Treatment of Substance Use Disorders (continued)

(b) Outpatient Services Facilities (continued)

(3) Medically Monitored Outpatient Withdrawal Management: Payment for medically monitored outpatient withdrawal management provided in an outpatient services facility shall be made at a per diem/per visit rate as established by the department pursuant to NH RSA 161:4, VI. The per diem rate was established based on the department's current rate for a 60 minute physician visit (99214).

(4) Peer Recovery Support: Payment for peer recovery support provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of July 1, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

(5) Non-Peer Recovery Support: Payment for non-peer recovery support provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of July 1, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

(6) Continuous Recovery Monitoring: Payment for continuous recovery monitoring provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of July 1, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

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ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

2. Services for Treatment of Substance Use Disorders (continued)

(c) Residential Treatment and Rehabilitation Facilities – Payment for services in residential treatment and rehabilitation facilities shall be made at a per diem rate based on level of intensity (low, medium, high, or specialty care such as extended services to pregnant women and children) as established by the department pursuant to NH RSA 161:4, VI.

Medicaid Premiums and Cost Sharing

State Name: New Hampshire

Transmittal Number: ___ - ___ - ___

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Cost Sharing Requirements — G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. **Yes**

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

- ☒ The state includes an indicator in the Medicaid Management Information System (MMIS)
- ☐ The state includes an indicator in the Eligibility and Enrollment System
- ☐ The state includes an indicator in the Eligibility Verification System
- ☒ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider
- ☐ Other process

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. **Yes**

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

- ■ Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;
- ■ Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;
- ■ Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

- [■] Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- [■] Provide a referral to coordinate scheduling for treatment by the alternative provider.

[✓] The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

The medical provider will be responsible for identifying emergency department services for a non-emergency purpose and collecting applicable cost-sharing.

After completing a medical screening, if the provider determines that the individual does not need emergency services, the provider will inform the individual of the amount of the co-pay for non-emergency use of the emergency room. The provider will also give the individual the name and location of an available and accessible alternative non-emergency services provider. The provider will determine whether the alternative provider can provide services to the individual in a a timely manner with the imposition of a lesser cost-sharing amount. Finally, the provider will offer to coordinate scheduling for treatment with the alternative provider.

An emergency medical condition means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

The state has established differential cost sharing for preferred and non-preferred drugs. Yes

- [■] The state identifies which drugs are considered to be non-preferred.
- [✓] The state assures that it has a timely process in place to limit cost sharing to the amount imposed for a preferred drug in the case of a non-preferred drug within a therapeutically equivalent or similar class of drugs, if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases, reimbursement to the pharmacy is based on the appropriate cost sharing amount.

Beneficiary and Public Notice Requirements

[✓] Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Medicaid Premiums and Cost Sharing

Other Relevant Information

PRA Disclosure Statement

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V.20140114

Medicaid Premiums and Cost Sharing

State Name: New Hampshire

Transmittal Number: ___ - ___ - ____

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Cost Sharing Amounts - Categorically Needy Individuals G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals.	No

PRA Disclosure Statement

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V.20140113

Medicaid Premiums and Cost Sharing

State Name: New Hampshire

Transmittal Number: __ - __ - __

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Cost Sharing Amounts - Medically Needy Individuals — G2b

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all medically needy individuals.	No

PRA Disclosure Statement

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V.20140116

Medicaid Premiums and Cost Sharing

State Name: New Hampshire

OMB Control Number: 0938-1148

Transmittal Number: __ - __ - ____

Expiration date: 10/31/2014

Cost Sharing Amounts - Targeting

G2c

1916
1916A
42 CFR 447.52 through 54

The state targets cost sharing to a specific group or groups of individuals. Yes

Population Name (optional): New Hampshire New Adult Group

Eligibility Group(s) Included: Adult group

Incomes Greater than 100% FPL TO Incomes Less than or Equal to 133% FPL

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Preferred Drugs	1.00	$	Prescription		X
+	Non-Preferred Drugs	4.00	$	Prescription		X
+	Non-Emergency Use of the ER	8.00	$	Visit		X

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. Yes

Providers may require payment of cost sharing as a condition for receiving all items or services listed above. Yes

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

Remove Population

Medicaid Premiums and Cost Sharing

Population Name (optional): Ticket to Work and Work Incentives Program

Eligibility Group(s) Included: Ticket to Work Group

Incomes Greater than 100% FPL TO Incomes Less than or Equal to 450% FPL

Service	Amount	Dollars or Percentage	Unit	Explanation
Preferred Drugs	1.00	$	Prescription	
Non-preferred Drugs	2.00	$	Prescription	

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. **Yes**

Providers may require payment of cost sharing as a condition for receiving all items or services listed above. **Yes**

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. **No**

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. **No**

Remove Population

Add Population

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140107

Medicaid Premiums and Cost Sharing

State Name: New Hampshire

Transmittal Number: ___ - ___ - ____

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Cost Sharing Limitations G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Medicaid Premiums and Cost Sharing

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over.	No
The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs.	Yes

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- [x] Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- [x] Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- [x] Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- [x] Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- [x] Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- [x] To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - [x] The state accepts self-attestation
  - [ ] The state runs periodic claims reviews
  - [ ] The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - [ ] The Eligibility and Enrollment and MMIS systems flag exempt recipients
  - [ ] Other procedure

  Additional description of procedures used is provided below (optional):

- [x] To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

- [ ] The MMIS system flags recipients who are exempt
- [ ] The Eligibility and Enrollment System flags recipients who are exempt
- [x] The Medicaid card indicates if beneficiary is exempt
- [ ] The Eligibility Verification System notifies providers when a beneficiary is exempt
- [ ] Other procedure

Additional description of procedures used is provided below (optional):

Payments to Providers

- [x] The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

- [x] The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

- [x] Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.
  - [x] The percentage of family income used for the aggregate limit is:
    - (•) 5%
    - ( ) 4%
    - ( ) 3%
    - ( ) 2%
    - ( ) 1%
    - ( ) Other: ___ %
  - [x] The state calculates family income for the purpose of the aggregate limit on the following basis:
    - (•) Quarterly
    - ( ) Monthly

Medicaid Premiums and Cost Sharing

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. **No**

Explain why the state's premium and cost sharing rules do not place beneficiaries at risk of reaching the aggregate family limit:

For individuals in the new adult group with incomes greater than 100% of the FPL, cost-sharing is limited to non-emergency use of the emergency room and prescription drugs. Cost-sharing levels for these services range from $1-$8. For individuals in current eligibility groups with incomes greater than 100% of the FPL who are not otherwise exempt from cost-sharing, cost-sharing is limited to $1 for preferred drugs and $2 for non-preferred drugs. Given the low amount of cost-sharing, it is very unlikely that any beneficiary with an income of at least 100% FPL would exceed 5% of his or her income in a given quarter.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. **No**

[■] Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

The beneficiaries may bring receipts to the Medicaid agency to demonstrate that they have paid cost-sharing in excess of the aggregate limit for the quarter. The Medicaid agency will review the receipts and reimburse beneficiaries for any amount above the aggregate limit.

[■] Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

At any time, beneficiaries may notify the Medicaid agency of a change in their income or other circumstance that might change their aggregate cost-sharing limit. Once a beneficiary notifies the Medicaid agency of such change, the Medicaid agency will review the updated information and change the aggregate limits, if necessary.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). **No**

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140116

State Plan Under Title XIX of the Social Security Act

State: New Hampshire

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on ________________________ . In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	Relevant Population Group Income Standard For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	Resource Proxy	Enrollment Cap	Special Circumstances	Other Adjustments
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	Attachment A, Column C, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	N/A	N/A	No
Disabled Persons, non-institutionalized	Attachment A, Column C, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	N/A	N/A	No
Disabled Persons, institutionalized	Attachment A, Column C, Line 3 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	N/A	N/A	N/A
Children Age 19 or 20	Not Covered	N/A	N/A	N/A	N/A
Childless Adults	Not Covered	N/A	N/A	N/A	N/A

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

   ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ■ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

   Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   The state:

   ☐ Applies existing state data from periods before January 1, 2014.

   ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

   ■ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ☐ Yes. The combined enrollment cap adjustment is described in Attachment C

   ■ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

   ☐ Applies a special circumstances adjustment(s).

   ■ Does not apply a special circumstances adjustment.

2. The state:

   ☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

   ■ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

☐ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

■ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

■ Does <u>NOT</u> meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

☐ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated __________.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

■ Does <u>NOT</u> qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated __________. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- [x] Attachment A – Conversion Plan Standards Referenced in Table 1
- [ ] Attachment B – Resource Criteria Proxy Methodology
- [ ] Attachment C – Enrollment Cap Methodology
- [ ] Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- [ ] Attachment E – Transition Methodologies

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 4 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan

NEW HAMPSHIRE

12/17/2013

	Population Group	Net standard as of 12/1/09	Converted standard for FMAP claiming	Same as converted eligibilty standard? (yes, no, or n/a)	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
Conversions for FMAP Claiming Purposes						
1	**Parents/Caretaker Relatives**			no	new SIPP conversion	SIPP
	Dollar standards by family size					
	1	$591	$639			
	2	$675	$739			
	3	$683	$763			
	4	$691	$788			
	5	$698	$811			
	6	$779	$909			
	7	$842	$988			
	8	$934	$1,097			
2	**Noninstitutionalized Disabled Persons**			n/a	new SIPP conversion	SIPP
	Dollar standards					
	Single	$688	$701			
	Couple	$1,012	$1,032			
3	**Institutionalized Disabled Persons** SSI FBR%	300%	300%	n/a	ABD conversion template	n/a
4	**Children Age 19-20**	n/a	n/a	n/a	n/a	n/a
5	**Childless Adults** FPL %	n/a	n/a	n/a	n/a	n/a

n/a: Not applicable.

New Hampshire
Department of Health and Human Services

Building Capacity for Transformation
Section 1115 Demonstration Waiver

Draft Application

April 28, 2014

Draft for Public Comment

Draft

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Building Capacity for Transformation Section 1115 Demonstration Waiver Application - Executive Summary

The New Hampshire Department of Health and Human Services (DHHS) is applying for a Section 1115 Demonstration Waiver from the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to support the continuing reform of its Medicaid program and to address critical mental health, substance use disorder (SUD), and population health priorities.

The primary purpose of New Hampshire's *Building Capacity for Transformation* Section 1115 Demonstration Waiver is to request authority to recognize costs not otherwise matchable in order to establish Designated State Health Programs (DSHPs).The initiatives proposed within this *Building Capacity for Transformation* Section 1115 Demonstration Waiver are designed to build on ongoing New Hampshire health care reforms and to enhance health care delivery in the State. They include improvements to the delivery of mental health, physical health, SUD, oral health, and population health programs and services.

This Demonstration Waiver application presents the rationale and data supporting the urgent need for Medicaid reform in these areas and how these programs compliment New Hampshire's overall health reform strategy, including the implementation of a Medicaid Care Management (MCM) program and the expansion of health coverage under the New Hampshire Health Protection Program. The *Building Capacity for Transformation* Section 1115 Demonstration Waiver will promote the improvement of overall health, will integrate and align with New Hampshire's recently launched MCM program, and will improve the quality of care and access to care for Medicaid and CHIP beneficiaries accessing mental health, SUD, oral health, and population health related services. This application revises and builds upon the Concept Paper submitted to CMS during the week of April 14, 2014 and distributed for public comment on April 21, 2014. In this Section 1115 Demonstration Waiver, the State will work with CMS to develop and implement five DSHPs.

DHHS proposes five programs focused on improving the delivery of mental health and SUD services, dental health services to select populations, and population health programs through payment reform. Through this Demonstration Waiver, DHHS proposes to:

1. Establish a community reform pool focused on mental health and physical health delivery system issues that rewards hospitals, health systems, and/or community providers for their active participation in system reform initiatives and their overall commitment to reform.
2. Implement components of its Ten Year Mental Health Plan and its December 2013 settlement agreement with the United States Department of Justice (U.S. DOJ) for the State's non-Medicaid population.
3. Establish a grant program that would fund training education and workforce development programs focused on SUD treatments and services.
4. Extend the current InShape program by establishing a funding pool to award grant applications from hospitals, health systems, and/or community providers to implement an InShape program that (1) include as participants children with serious mental illness (SMI), (2) include as participants those enrolled in New Hampshire's 1915(c) Home and Community Based Services

Waiver for Developmentally Disabled (HCBS-DD), and (3) includes a smoking cessation component for all InShape participants who smoke.

5. Establish a pilot program to demonstrate the impact on children's oral health and improved birth outcomes by providing oral health education, tobacco cessation, and Medicaid coverage for dental services to women during pregnancy and up to the child's fifth birthday.

The design and improvements made by each DSHP program will demonstrate that by spending Medicaid dollars differently, DHHS can provide better health outcomes for its Medicaid clients, and these outcomes will be defined and measured throughout the length of this Demonstration. This action will not result in a loss of revenue or an increase in State funds associated with the Medicaid program. New Hampshire will maintain budget neutrality over the five-year lifecycle of its *Building Capacity for Transformation* Section 1115 Demonstration Waiver, with total spending under the waiver not exceeding what the federal government would have spent without the waiver.

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Building Capacity for Transformation Section 1115 Demonstration Waiver Application - Introduction

This proposal describes a Demonstration Waiver under Section 1115(a) of the Social Security Act for costs not otherwise matchable that is designed to build on existing New Hampshire health care reforms to continue the reform of New Hampshire's health care delivery and payment systems in a manner that is consistent with the CMS' Triple Aim. The Demonstration Waiver will improve the health of populations and contain health care costs, as well as improve the quality of care. The State seeks to establish Designated State Health Programs (DSHPs) to support transforming the Medicaid care delivery system through this Demonstration. This *Building Capacity for Transformation* Section 1115 Demonstration Waiver will promote the improvement of overall health, will integrate and align New Hampshire's Medicaid Care Management (MCM) program, and will improve the quality of care and access to care for Medicaid and CHIP beneficiaries accessing mental health, substance use disorder (SUD), oral health, and population health programs and services.

New Hampshire requests authority to recognize and receive federal financial participation (FFP) for costs not otherwise matchable for mutually agreed upon local and state designated health program services. The additional state and local funds that result from additional federal matching funds would be used to provide financial assistance to implement the state's Ten Year Mental Health Plan and delivery system reforms that will help improve the New Hampshire mental health care system as coverage expansion begins in July 2014. Costs not otherwise matchable are incurred by the following state agencies, local governments, and health systems:

- Department of Health and Human Services (DHHS)
- Department of Corrections
- Counties
- Municipalities

To establish DSHPs, DHHS is requesting approximately $78.6 million (all funds) each year over the five year term of the waiver, with approximately $39 million in additional FFP annually. A list of identified non-federal funding sources is included as *Attachment A: Resources for Costs Not Otherwise Matchable / Designated State Health Programs*. The programs included within *Attachment A,* which are incurring costs but not otherwise matchable, provide vital services that today are not reimbursed by Medicaid or any other Federal source.

The DSHPs funded under this Section 1115 Demonstration Waiver are designed to promote innovation, reform delivery and payment systems, and reduce the number of uninsured patients who seek treatment from health care providers. These programs are vital to the successful transformation of the health care delivery system, spanning mental health, physical health, public health, oral health, and community-based services. Currently, state and local funds support these programs because Medicaid, as it is currently structured, does not. The populations affected by the proposed DSHPs and served using the demonstration funding receive services alongside Medicaid eligible individuals, who also are part of the 'churn' in and out of Medicaid. New Hampshire is requesting federal investment in these programs in recognition that they are vital to

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improving the health of Medicaid enrollees and the communities in which they live.

Federal funding for these services is critical to stabilizing the mental and physical health delivery system, providing a foundation for expanded coverage that will begin in 2014 when many recipients of these services will gain health coverage, and for increasing capacity for the provision of important new benefits made available under the Affordable Care Act, such as the new SUD benefit, which will be implemented initially for the new adult group under the New Hampshire Health Protection Program. New Hampshire's request to CMS is patterned after approved requests in other states (e.g., New York, New Jersey, California, Texas and Massachusetts). CMS approval of this request will allow the State to move forward to meet its healthcare reform goals.

Section I - Program Description and Historical Context

Background and Current State

DHHS' mission is to join communities and families in providing opportunities for citizens to achieve health and independence. As such, New Hampshire is consistently ranked as one of the healthiest states in the U.S. according to United Health Foundation's America's Health Rankings, but there is still more work to do. For example, the Department's recent State Health Improvement Plan documents that tobacco use and dependence "remains the single most preventable cause of death and disability in New Hampshire. Helping those who are tobacco dependent and preventing kids from starting tobacco use can save many lives and health care dollars".[1] This finding and its implications for population health and health costs in New Hampshire is why the Department has included in its Demonstration Waiver proposals to implement a tobacco cessation component into the current InShape program for adult and adolescent participants and into the oral health pilot program for pregnant women and mothers of young children.

New Hampshire has taken significant steps toward addressing population health needs in its overall health reform efforts. Four key themes, as illustrated in the graphic below, reflect New Hampshire's approach to health care reform, which focuses on quality, outcomes, and costs, and are driving forces for the initiatives proposed by DHHS in this Demonstration Waiver. In order to support the implementation of these multiple strategic initiatives, DHHS is undergoing a department-wide organization redesign that supports a whole-person approach to service delivery.

[1] New Hampshire Department of Health and Human Services, Division of Public Health Services. "State Health Improvement Plan 2013-2020: Charting a Course to Improve the Health of New Hampshire." December 2013. <http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf>.

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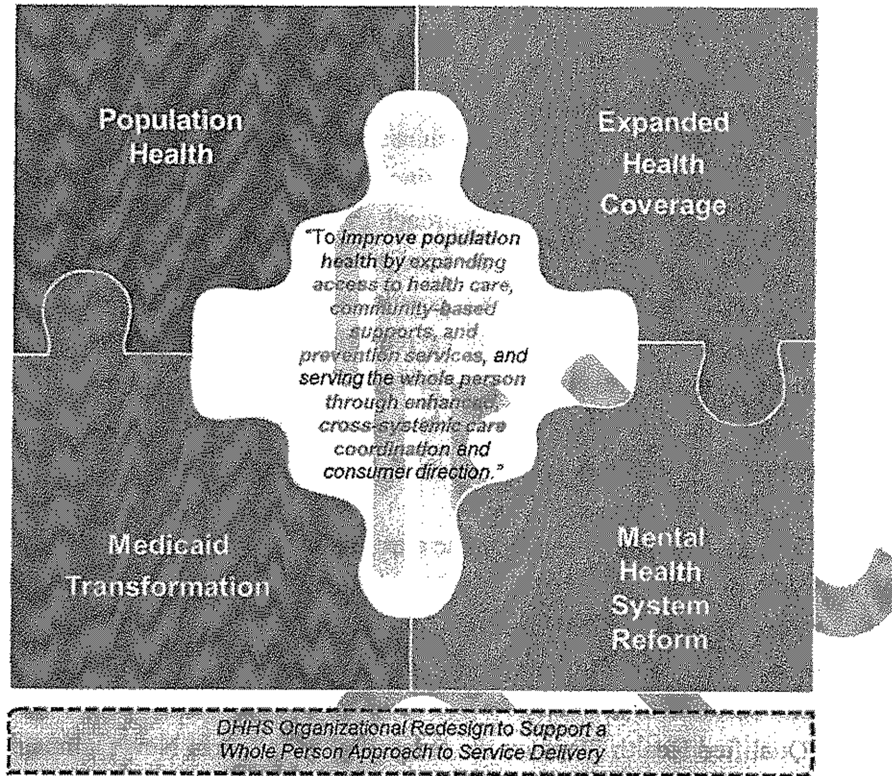
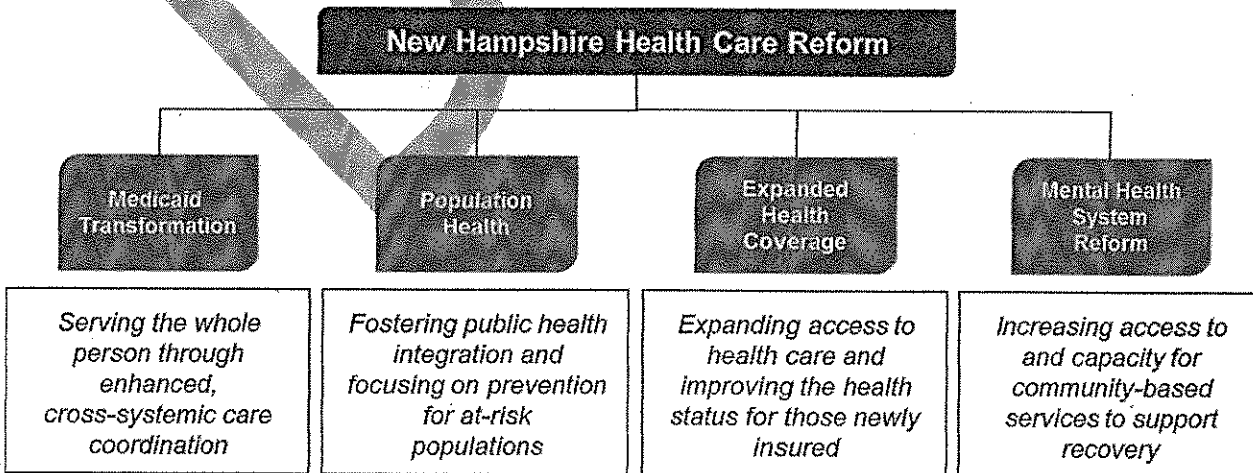


The graphic and subsequent sections below review the steps DHHS has taken toward health care reform and outline the role of each strategic initiative as the a collective catalyst for this *Building Capacity for Transformation* Section 1115 Demonstration Waiver.



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Comprehensive Medicaid Reform

Medicaid Transformation

New Hampshire in currently engaged in the comprehensive reform of its Medicaid program and its health care delivery system through its Medicaid Care Management (MCM) program. New Hampshire Senate Bill (SB) 147 was signed into law by the Governor in June 2011, mandating a MCM program in the State. The MCM program is being implemented by DHHS via a three-step approach that recognizes the issues of providing specialty services for vulnerable populations. The first step of the program launched on December 1, 2013 and included the mandatory enrollment of all Medicaid populations, with the exception of those dually eligible for Medicare and Medicaid (dual-eligibles), and those requiring long term services and supports (LTSS) including nursing homes services. These groups are permitted to opt out of MCM until all populations are later mandated in. Currently, there are over 116,000 beneficiaries that are receiving health care coverage through the three managed care organizations (MCOs) in the MCM program.

The second step of MCM implementation will be the enrollment of the New Hampshire Health Protection Program population that will begin as early as July 2014. Over 50,000 newly eligible adults will receive health benefits under the New Hampshire Health Protection Program that includes a mandatory Health Insurance Premium Program (HIPP) for those newly eligible with access to cost-effective employer sponsored insurance and enrollment in managed care coverage for those non-HIPP eligible new adults, pending transition to Qualified Health Plans on the federal marketplace in New Hampshire under a proposed Premium Assistance waiver.

The third and final implementation step will require MCM enrollment for the dual-eligibles, those receiving Medicaid community-based waiver services, and the inclusion of LTSS and nursing home services in MCM. Within MCM, the MCOs are seen as change agents encouraging innovative payment and delivery reform within the health care system. New Hampshire requires each MCM MCO to submit a payment reform plan describing how the agency will engage providers in new and innovative payment and delivery strategies. Beginning in July 2014, the MCOs will have one percent (1%) of their capitation withheld and then could earn it back when the MCO successfully implements their payment reform plan.

This *Building Capacity for Transformation* Section 1115 Demonstration Waiver is a critical element of DHHS' broader MCM strategy that is focused on addressing the needs of MCM enrollees holistically and improving the coordination of care for enrollees who are served by multiple systems of care. The first step of the MCM program began the integration of behavioral health and mental health care in the State and the MCM roll out will continue to improve the integration of and access to needed services, with an emphasis on both mental health and SUD treatment services. To begin progressing towards this goal, DHHS is proposing five related DSHPs within this Section 1115 Demonstration Waiver, which are described in more detail below.

In February 2013, CMS's Center for Medicare and Medicaid Innovation (CMMI) awarded New Hampshire a State Innovation Model (SIM) Model Design grant to develop a State Health Care Innovation Plan and associated delivery system reform and payment reform models. New Hampshire focused its SIM design on models that work to reform the provision of LTSS in the State. It is important to note New Hampshire

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included Community Mental Health services in its definition of LTSS services and actively engaged mental health providers in the develop of the SIM plan. The reform goals developed through the SIM process include improving access to care, promoting consumer direction, and strengthening linkages to acute medical care services for persons receiving LTSS across the continuum of care. New Hampshire is anticipating the forthcoming Funding Opportunity Announcement (FOA) from CMMI in order to determine how its SIM design goals may be advanced either through a SIM Testing grant application or in conjunction with this *Building Capacity for Transformation* Section 1115 Demonstration Waiver.

Population Health

In addition to its Medicaid transformation initiatives described in detail above, DHHS recently released its State Health Improvement Plan (SHIP) that will act as the State's public health road map to guide health improvement work throughout New Hampshire. The SHIP defines measurable objectives, recommended strategies for improvement, and performance measures with time-framed targets for ten population health focus areas, including tobacco use, obesity/diabetes, healthy mothers and babies, and the misuse of alcohol and drugs. The SHIP aims to assist state and community leaders in focusing their work to improve the public's health and to promote coordination and collaboration among public health partners, which has been reflected in the development of NH's *Building Capacity for Transformation* Section 1115 Demonstration Waiver.

Expanded Health Coverage

The New Hampshire Health Protection Program will be expanding health coverage in three different ways: (1) through a Mandatory Health Insurance Premium Program (HIPP) that will help eligible workers pay for employer-sponsored insurance through calendar year 2016; (2) through a Voluntary Bridge to Marketplace plan that will offer coverage to eligible individuals through either Managed Care Organizations (MCOs) or Qualified Health Plans (QHPs) on the exchange in calendar year 2014; and (3) through a Mandatory Premium Assistance Program that will provide coverage for eligible adults through QHPs on the exchange beginning in 2016.

In addition, New Hampshire will be introducing a SUD benefit for the newly eligible childless adult population enrolled in the New Hampshire Health Protection Program. With the addition of this benefit into the New Hampshire Health Protection Program, the newly eligible population would have access to new SUD screening and treatment services. New Hampshire has seen an alarming increase in the abuse of prescription and illegal drugs in the State such as heroin and other opioids, as has occurred across the nation. This combination of an increasing need for screening and treatment services and the implementation of a SUD benefit will have an impact on an already overburdened provider network. There is a critical need to support providers as they respond to this growing need for SUD services, both through training and additional capacity.

Mental Health System Reform

The final element of New Hampshire's comprehensive reform of its Medicaid program focuses on mental health system reform. On September 22, 2008, DHHS released "Addressing the Critical Mental Health Needs of NH's Citizens – A Strategy for Restoration", the Ten Year Plan for the State's public mental health system. In order to implement the community-based programs prescribed by this plan, the State is making new investments in its mental health system for the first time in nearly a decade. The State's current Biennial

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Budget provides over $26 million in new funding for mental health programs and the State will be investing an additional $65 million in new community resources over the next four fiscal years as well.

Problem Statement

New Hampshire recognizes that there is a need to restructure how the State delivers mental health and SUD services to better integrate those services with the medical and LTSS services that residents receive. A recent review commissioned by Governor Hassan of the mental health services in Manchester emphasizes that "a variety of factors – [lack of public and private resources,] the economic downturn, increased substance abuse, reductions in state hospital beds, reductions in psychiatric beds at New Hampshire hospitals, and reductions in community based services – have all contributed to New Hampshire's strained mental health system and that changes are needed at all levels to provide more appropriate and more effective mental health care to those in need".[2] New Hampshire sees a strong opportunity to link these necessary mental health system reforms with the other reform initiatives previously described, and intends to use its *Building Capacity for Transformation* Section 1115 Demonstration Waiver to request DSHP funding as a catalyst to do so.

For example, as depicted in the table below, many children and adults are waiting far too long for mental health treatment, creating an ongoing crisis for both the provider and patients. On average during State Fiscal Year 2014, there were 14 to 34 individuals awaiting admission into one of New Hampshire Hospital's 158 beds, primarily from emergency rooms across the State.

New Hampshire Department of Health and Human Services			
Average number of individuals awaiting admission to New Hampshire Hospital (158 beds) during Fiscal Year 2014 to date[3]			
Month	Count of Adults	Count of Children	Total Count
July 2013	16	3	19
August 2013	31	3	34
September 2013	25	4	29
October 2013	23	5	28
November 2013	21	7	28
December 2013	22	2	24
January 2014	18	4	22
February 2014	15	8	23
March 2014	11	3	14

[2] Nadeau, Joseph P, Alexander P. de Nesnera and Michael K. Brown. "New Hampshire Mental Health Sentinel Event Review Report." January 2014. 2014 April 10 <http://www.governor.nh.gov/media/news/2014/documents/pr-2014-01-28-mental-health.pdf>.

[3] Provided by New Hampshire Department of Health and Human Services, New Hampshire Hospital on April 3, 2014. New Hampshire Hospital does not track how long those individuals have waited, or those waiting for a small number of other DRF beds in the State (1 Crisis Bed setting and 2 small community hospital units).

This data suggests that there is an inherent need to increase the number of psychiatric providers in the State, and to train and educate emergency room physicians on handling complex mental health and SUD patients. Similarly, New Hampshire's provider network's capacity to support the SUD treatment needs of its citizens is shrinking. With the addition of an SUD benefit into the State's Medicaid program, this lack of capacity will only intensify. There is an inherent need to shift and/or improve on how SUD treatments are delivered, and one way to do so is by increasing the delivery of these treatments through hospitals, health systems, and/or community providers, e.g. community mental health centers (CMHCs), federally qualified health centers (FQHCs), and rural health clinics (RHCs).

The data to substantiate these claims are evident. As depicted in the table below, in State Fiscal Years 2011 and 2012, 33 percent of all adult Medicaid beneficiaries had mental health and/or SUD diagnosis, increasing by almost 1,000 beneficiaries from the previous year. The linkages between these two service categories combined with the lack of capacity to provide treatment and services to this population are the delivery challenges this waiver seeks to address.

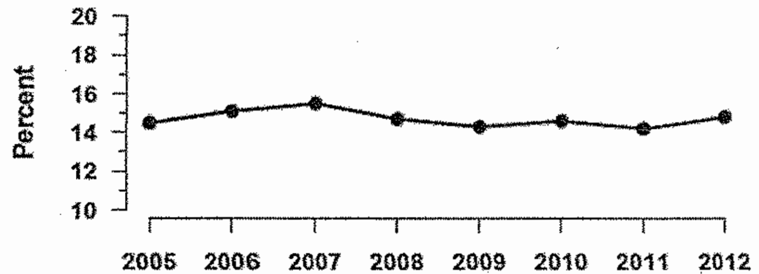
New Hampshire Department of Health and Human Services				
Beneficiaries with Mental Health and/or SUD Diagnosis[4]				
Fiscal Year	Age Category	Total Beneficiaries	MH/SUD Beneficiaries	Percent MH/SUD
FY10/11	Adult	57,093	33,435	58.6%
FY10/11	Child < 19	106,581	20,548	19.3%
FY10/11	All	163,674	53,983	33.0%
FY11/12	Adult	57,253	33,991	59.4%
FY11/12	Child < 19	107,249	20,955	19.5%
FY11/12	All	164,502	54,946	33.4%

In addition to proposing solutions for improving the mental health and SUD delivery system in the State, this Demonstration Waiver will focus on promoting the overall health of individuals with a persistent and/or severe mental illness. According to Dr. Stephen Bartels, the director of Dartmouth's Centers for Health and Aging and professor of health policy at the Dartmouth Institute for Health Policy and Clinical Practice, a person with a serious mental illness, on average, has a life span that is 25 years shorter than a person in the general population.[5] For persons with a persistent and/or severe mental illness staying physically healthy and fit is a special challenge; yet regular exercise and proper diet can be key elements in recovering from a major mental or emotional illness. DHHS recognizes the opportunity to use this Demonstration Waiver as means for expanding population health programs currently in place in the state to reach a broader segment of this population, to include children and developmentally disabled adults.

[4] Count of every Medicaid enrollee who received a Medicaid paid service with mental health and/or SUD diagnosis code provided by Milliman on April 13, 2014. Mental health and/or SUD diagnosis codes are defined by SAMSHA, excludes tobacco use disorder.

[5] Dartmouth College, Office of Public Affairs. Dartmouth Now: Fitness Program for Mentally Ill Expands in New Hampshire (Associated Press). 23 February 2012. 23 April 2014 <http://now.dartmouth.edu/2012/02/fitness-program-for-mentally-ill-expands-in-new-hampshire-associated-press/>.

Women in New Hampshire who report smoking cigarettes during pregnancy[6]



The final component of this Demonstration Waiver focuses on reducing tobacco smoking and improving oral health education among pregnant women and mothers of young children. According to 2011 NH Birth Data published in the New Hampshire SHIP, 31.9 percent of pregnant women on Medicaid smoke.[7] In comparison with the statewide population, 13.6 percent, report smoking during pregnancy. 26.3 percent of teenage pregnant women (up to 19 years of age) report smoking during pregnancy, compared to 13 percent of women age 20 or older. Smoking during pregnancy is associated with higher risk for poor birth outcomes often requiring hospitalization for the infant, mother or both. The estimated smoking attributable neonatal health care costs annually in New Hampshire are $585,000.[8]

Population-based studies have demonstrated an association between periodontal diseases and adverse pregnancy outcomes, diabetes, cardiovascular disease, and stroke. There is a known correlation between maternal periodontal disease and preterm birth and/or low birth weight.[9] Further research is needed to determine the extent to which these associations are causal or coincidental. A reduction in adverse birth outcomes and associated costs, and a decrease of perinatal morbidity and mortality would likely result from improving oral health during pregnancy.[10]

The March of Dimes estimated that the average costs during the first year of life for a premature and/or low birth weight baby (less than 37 weeks gestation and/or less than 2,500 grams) were more than ten times as high as medical costs for a baby born at full term ($55,393 versus $5,085).[11] In State Fiscal Year 2012, New Hampshire Medicaid covered and paid $7.9 million for all services provided in the first month of life for

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[6] New Hampshire Department of Health and Human Services, Division of Public Health Services. "State Health Improvement Plan 2013-2020: Charting a Course to Improve the Health of New Hampshire." December 2013. <http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf>.

[7] New Hampshire Department of Health and Human Services, Division of Public Health Services. "State Health Improvement Plan 2013-2020: Charting a Course to Improve the Health of New Hampshire." December 2013. <http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf>.

[8] *These amounts do not include health costs caused by exposure to secondhand smoke, smoking-caused fires, smokeless tobacco use, or cigar and pipe smoking.*

[9] American College of Obstetricians and Gynecologists. "Committee Opinion No. 569: Oral Health Care During Pregnancy and Through the Lifespan." Obstetrics & Gynecology 122 (2013): 417-22. <http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Oral_Health_Care_During_Pregnancy_and_Through_the_Lifespan#19>.

[10] Xiong, X, et al. "Periodontal disease and pregnancy outcomes: state-of-the-science." Obstetrical & Gynecological Survey 62.9 (2007): 605-15.

[11] March of Dimes. "Premature Babies Cost Employers $12.7 Billion Annually." 7 February 2014. March of Dimes Releases New Report about the High Cost of Preterm Birth. 12 April 2014 <http://www.marchofdimes.com/news/premature-babies-cost-employers-127-billion-annually.aspx>.

780 low birth weight and/or preterm babies.[12] The medical services needs and costs for low birth weight and preterm babies throughout their lifetime are much greater. Below is a chart summarizing the count of preterm births and/or low weight birth covered by New Hampshire Medicaid in the past two State Fiscal Years.

New Hampshire Department of Health and Human Services				
Count of Pre-Term and/or Low Birth Weight Newborns[13]				
State Fiscal Year	Low Birth Weight & Pre-Term	Low Birth Weight Only	Pre-Term Only	Total Newborns with Low Birth Weight and/or Pre-Term
SFY10/11	341	14	483	838
SFY11/12	327	13	440	780

In addition to reducing costs associated with poor birth outcomes, improving perinatal oral health also has potential to improve the oral health of children. According to the Children's Dental Health Project (CD HP), evidence suggests that there is a correlation between improved oral health and reduced costs for dental treatment in children whose mothers receive routine dental care. Transmission of bacteria from mother to child is the dominant course through which children first acquire dental decay or cavities. Bacteria could be passed through saliva from a caregiver's mouth to a child's, such as when sharing a spoon or food. The healthier the mother's mouth, then the longer the initial transmission of tooth decay-causing bacteria is delayed and the more likely children are to establish and maintain good oral health.[14]

In New Hampshire, visits related to non-traumatic dental conditions increased significantly in ambulatory care sensitive emergency departments from 2001 to 2007, from 11,067 (age-adjusted rate 89.5 per 10,000 population) in 2001 to 16,238 (age adjusted rate 129.3 per 10,000 population) in 2007. [15] Improving women's oral health during pregnancy and throughout her child's early childhood may decrease these incidences and the costs associated with treatment for early childhood tooth decay and cavities.

Components of Section 1115 Demonstration Waiver

Based upon the delivery system challenges outlined above, DHHS developed a list of five Designated State

[12] Total cost of Medicaid services provided by DHHS to low birth weight and/or preterm babies in SFY2012 calculated and provided by Milliman on April 13, 2014.
[13] Count of Pre-Term and/or Low Birth Weight Newborns Paid by New Hampshire Medicaid in State Fiscal Years 2011 and 2012 provided by Milliman on April 13, 2014.
[14] Children's Dental Health Project and National Institute for Health Care Management Research and Educational Foundation. "Improving Access to Perinatal Oral Health: Strategies and Considerations for Health Plans." July 2010. Issue Brief. April 2014 <http://www.nihcm.org/pdf/NIHCM-OralHealth-Final.pdf>.
American Academy of Pediatric Dentistry. *Guideline on Perinatal Oral Health Care.* Chicago, IL: American Academy of Pediatric Dentistry, 2009.
[15] New Hampshire Department of Health and Human Services, Division of Public Health Services. "State Health Improvement Plan 2013-2020: Charting a Course to Improve the Health of New Hampshire." December 2013. <http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf>.

Health Programs (DSHPs) that it is seeking funding for from CMS through this *Building Capacity for Transformation* Section 1115 Demonstration Waiver. These programs were also developed to address the public health needs identified in the New Hampshire State Health Improvement Plan (SHIP), as DHHS recognizes how hospitals, health systems, and/or community providers, e.g. community mental health centers (CMHCs), federally qualified health centers (FQHCs), and rural health clinics (RHCs) must be strong partners in driving the health outcomes outlined in the SHIP.

Through the development of the proposed statewide DSHPs, DHHS is seeking to improve access to quality, affordable health care by:

- Encouraging hospitals, health systems, and community providers to build an integrated system at the local level by establishing a new community reform pool that would reward providers for their active participation in system reform initiatives and their overall agreement to reform
- Expanding community-based mental health services for the State's non-Medicaid population in accordance with the Ten Year Mental Health Plan and its settlement with the U.S. DOJ
- Improving the service delivery of mental health and SUD services, especially in Emergency Departments, by offering financial resources for workforce development
- Promoting healthy behaviors and improved health outcomes by expanding the InShape program at hospitals, health systems, and community providers to additional populations – children and 1915(c) Developmentally Disabled Waiver enrollees – and to include smoking cessation classes as a component for adults
- Increasing access to dental services by establishing a pilot program that creates a dental benefit for adult pregnant women and mothers of young children

Demonstration Hypotheses and Evaluation Design

The State will submit to CMS for approval an evaluation design for the Demonstration no later than 120 days after CMS approval of the Demonstration. The overarching objective of the Demonstration is that implementation of the five DSHPs will result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement. The State will test the following research hypotheses through this Demonstration:

- Maintaining and increasing access to mental health services will lead to improvement in the overall health status of the Medicaid population
- Supporting community based delivery system reforms will result in improved access to mental health, SUD, and physical health services
- Increasing SUD workforce development opportunities for health care providers will result in the increased capacity to provide needed SUD treatments and services
- Expanding successful community public health programs statewide will improve health and wellness of those who participate
- Offering dental coverage to pregnant women and mothers of young children will reduce the frequency of low birth weight babies, babies born with complications, and improve the dental health status of the new mothers' children

The design and improvements made by each DSHP program will demonstrate that by spending Medicaid dollars differently, DHHS can provide better health outcomes for its Medicaid clients, and these outcomes will be defined and measured throughout the length of this Demonstration. The State's evaluation design for the Demonstration will:

- Test the hypotheses described above;
- Describe specific outcome measures that will be used in evaluating the impact of each Demonstration-related program during the period of approval;
- Detail the data sources and sampling methodologies for assessing these outcomes;
- Describe how the effects of all Demonstration-related programs will be isolated from other initiatives occurring in the State; and
- Discuss the State's plan for reporting to CMS on the identified outcome measures and the content of those reports.

No later than 60 days after receiving comments on the draft evaluation design from CMS, the State will submit the final design to CMS. The State will submit progress reports in quarterly and annual Demonstration reports, and submit a draft final evaluation report within 120 days of the expiration of the Demonstration.

Section II – Designated State Health Programs

The next section includes detailed descriptions for each Designated State Health Program (DSHP) proposed within this *Building Capacity for Transformation* Section 1115 Demonstration:

- Establish a Community Reform Pool focused on mental health and improved care coordination of individuals with a mental health and physical health comorbidity
- Enhance Community Based Mental Health Services
- Invest in Substance Use Disorder (SUD) Workforce Development
- Expand the InShape program
- Launch Oral Health Pilot Program for Pregnant Women and Mothers of Young Children

Establish a Community Reform Pool

DHHS proposes to establish a community reform pool that would reward New Hampshire hospitals, health systems, and community providers for their active participation in system reform initiatives and their overall commitment to reform. This reform pool would encourage hospitals, health systems, and community providers to maintain and expand needed mental health/SUD services and to build an integrated physical health, mental health, and SUD system at the local level. DHHS envisions that in-state providers could receive higher rates of reimbursement and/or additional pool payments based upon their participation, which would occur through the following five components.

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Five Components of Community Reform Pool	
Reform Pool	**Description**
1. Capacity-retention Payments	• A hospital would receive this payment if it pledged not to reduce access to mental health/SUD related services in their health system • This payment would be 10 percent of the hospital's existing Medicaid claim payments for mental health/SUD related services in their system, based on previous years. This payment would be in place each year of the five year waiver program
2. Capacity-expansion Payments	• If a hospital, health system, or community provider expands its physical capacity to provide mental health/SUD related services, DHHS would pay an enhanced rate for those services provided through the new "unit" for three years, using a 25 percent payment increase
3. New Service Payments	• If a hospital, health system, or community provider adds inpatient or outpatient mental health/SUD related services, DHHS would pay an enhanced rate for those services for three years, using a 10 percent payment increase
4. Pilot Program Pool	• Establish a pool for DHHS to fund grant applications from hospitals, health systems, or community providers to form pilots related to improving the delivery and coordination of physical health, mental health, and/or SUD treatments and services • Grant applications would be evaluated by DHHS based upon a defined set of criteria
5. Provider Incentive Pool	• Establish a pool that would begin to provide financial incentives in Year 3 of the demonstration, based upon a hospital, health system, and/or community provider's ability to meet defined outcome measurements • This incentive pool would be funded by a 20 percent holdback in all four components of this broader community reform pool • These hold backs would begin to accrue in Year 2 of the demonstration

The first component addresses capacity reduction and access to mental health care for Medicaid recipients. A hospital would receive this type of payment if it pledged not to reduce access to mental health/SUD related services in their health system.

These payments could reduce a trend of closing or downsizing facilities in the state. As published in the Ten Year Mental Health State Plan, inpatient and residential alternatives to New Hampshire Hospital have diminished since the 1990s. There were 236 voluntary inpatient beds in 1990 across the state, 186 beds in 2008, and 177 beds in 2014.[16] A Designated Receiving Facility (DRF) is a hospital-based psychiatric inpatient unit or a non-hospital-based residential treatment program designated by the Commissioner of DHHS to provide care, custody, and treatment to persons involuntarily admitted to the state mental health services system. The number of community DRFs' beds has decreased dramatically in the 2000s from 101 to currently 16, as have the number of Acute Psychiatric Residential Treatment Program (APRTP's) beds (from 52 to 16).

[16] New Hampshire Department of Health and Human Services. "Addressing the Critical Mental Health Needs of New Hampshire's Citizens - A Strategy for Restoration: Ten Year Mental Health Plan." 17 September 2008. 10 April 2014 <http://www.dhhs.nh.gov/dcbcs/bbh/documents/restoration.pdf>.
Additional information provided by New Hampshire Department of Health and Human Services, Bureau of Behavioral Health Services on April 8, 2014.

The second component of the community reform pool addresses the need to increase capacity by offering a financial incentive to hospitals, health systems or community providers that expands their capacity to provide mental health/SUD related services. DHHS would pay an enhanced rate for those services provided through the new "unit" for three years. Currently, the State is lacking regional capacity for inpatient voluntary and involuntary care. DRF or APRTP care is currently only available at four locations. DHHS has been forced to add capacity to New Hampshire Hospital, which is costly and only addresses the issue of involuntary bed capacity.

New Hampshire Department of Health and Human Services	
Designated Receiving Facilities (DRF) Beds in New Hampshire [17]	
New Hampshire Hospital	158
Elliot Hospital	6
The Cypress Center (APRTP)	16
Franklin Hospital	10
Total	**190**

As described in the Ten Year Mental Health Plan, "Expanding capacity within local general hospitals would allow people to be treated in their own region makes more sense. Inpatient care has diminished because this care is not financially viable for providers." This Section 1115 Demonstration Waiver presents an opportunity for health care entities to reassess the feasibility and viability of expanding capacity or offering new services for those with mental health and/or SUD needs.

The third component of the reform pool addresses mental health/SUD services by offering a financial incentive to a hospital, health system, or community provider that adds inpatient or outpatient mental health/SUD related services. DHHS would pay an enhanced rate for those new services for three years.

With few exceptions, acute care hospitals in the state have drastically reduced inpatient mental health care, many citing cost concerns. These trends have occurred in New Hampshire and nationally due to a combination of factors, including changes in Medicare and Medicaid funding, and a growing uninsured segment of the population. "The Medicaid reimbursements are so low, and the costs so high, that it just became cost-prohibitive," said John Clayton, spokesman for the New Hampshire Hospital Association.[18] The proposed changes to funding for hospitals, health systems, and/or community providers under the waiver will impact more than 271 providers that received payments for mental health/SUD services under the Medicaid state plan in State Fiscal Year 2012. Implementing these three reform pools together enables them to reinforce each other and create more momentum for strengthening New Hampshire's mental health/SUD delivery system while bending the cost curve. Enhanced payment rates introduce marketplace sustainability and incentivize adding capacity into the mental health delivery system, thereby sustaining the

[17] Count of DRF Beds in New Hampshire provided by New Hampshire Department of Health and Human Services, Bureau of Behavioral Health Services on April 8, 2014.
[18] Solomon, Dave. "NH mental health report: More beds needed." New Hampshire Union Leader 26 February 2014: <http://www.unionleader.com/article/20130227/NEWS12/130229277/0/SEARCH>.

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expanding individual insurance market as a result of the ACA and New Hampshire's partnership with the Federal Market Place.

The fourth component of the reform pool establishes a pilot program pool to fund grant applications submitted by hospitals, health systems, and/or community providers to form pilots related to improving health care delivery in their communities through improved care coordination, especially for individuals with physical and mental health co-morbidities. It presents an opportunity for health systems and providers to address pressing issues and propose their own tailored solutions. By using an application approach with providers, this program would incentivize hospitals, health systems, and/or community providers to create and customize pilot programs tailored to their community's needs. DHHS would solicit and approve a wide variety of pilot program proposals across the state. Suggested pilot program may focus on, but not limited to, delivery of physical health, mental health, and/or SUD treatments and services at the local level. For each grant application put forth for the pilot program pool, providers would be required to describe its pilot program, discuss intended outcomes and populations served, and present outcome measures. This component is also directly linked to New Hampshire's overarching interest in encouraging payment and delivery reform within the health care system. Within the design of its MCM program, New Hampshire has created an innovate payment reform incentive pool where each of the MCM MCO's is required to submit a payment reform plan detailing how it will engage providers in new and innovative payment and delivery strategies to improve the delivery and coordination of care. Beginning in July, 2014 the MCOs will have one percent (1%) of their capitation withheld and then paid back if the MCO successfully implements their plan. It is anticipated that a number of hospitals, health systems and other providers will use this pilot pool to support the implementation of payment and delivery reform strategies developed in conjunction with the MCOs.

The fifth and last component is a provider incentive pool that would begin to provide rewards in demonstration year (DY) 3, based upon a hospital, health system, or community provider's ability to meet defined outcome measurements. These are rewards paid to providers for achieving outcome measures proposed in pilot program's grant application. This pool would be funded by withholding 20 percent of mental health reform pool payments in the previous demonstration year. Payment rewards would be at-risk if providers do not achieve outcomes. Improvements will drive whether or not hospitals, health systems, and/or community providers benefit from the incentive pool. New Hampshire recognizes that hospitals, health systems, and community providers will need to prepare and adapt to new outcome-based payment structures proposed under the Demonstration. In DY 1, providers would receive all payment amounts from the abovementioned components of the reform pool. In DY 2, 20 percent of payments from the mental health reform pool will be withheld, and providers will have the opportunity to earn back their 20 percent in DY 3 if outcome measures are achieved.

The community reform pool components will help fund delivery system and payment reforms that will lead to increased accountability and lasting improvements in health care delivery across New Hampshire. Payments from this pool will help providers prepare to meet new coverage demands beginning in July 2014. Hospitals, health systems, and/or community providers eligible to receive funding from the payment pool must have contracts with at least one Medicaid MCO and beginning in 2016 have contracts with at least one Qualified Health Plan offered on the New Hampshire Marketplace that is enrolling Medicaid eligible

members who are receiving premium assistance from DHHS, as well as meet any related objectives, reporting and metrics identified for the provider.

All of the abovementioned payments will be in the form of supplemental payments. The expenditure plan showing the allocation between reform pool components over the five-year waiver period will be included at a later date in the Appendices.

Enhance Community Based Mental Health Services

On September 22, 2008, the Department of Health and Human Services (DHHS) released "Addressing the Critical Mental Health Needs of NH's Citizens – A Strategy for Restoration", the Ten Year Plan for the State's public mental health system. It was the result of a DHHS Commissioner-appointed task force, charged with identifying the critical mental health needs of New Hampshire's citizens. Among the areas identified in this report as needing attention are housing and residential supports; more community supports to prevent hospitalization; mental health workforce retention and development; capacity for community-based inpatient psychiatric care; services for special populations; and an increase in Assertive Community Treatment (ACT) teams.[19] The report is available at http://www.dhhs.nh.gov/dcbcs/bbh/documents/restoration.pdf.

The taskforce made recommendations in the following areas:

- Increase the Availability of Community Residential Supports
- Increase Capacity for Community-Based Inpatient Psychiatric Care
- Develop Assertive Community Treatment Teams
- Community Mental Health Workforce Retention and Development
- Department of Corrections Study Committee Planning Considerations

The taskforce recommended that group homes, which provide consumers with a safe, supportive living environment, be developed and used as an alternative to state mental health facilities, including New Hampshire Hospital ("NHH") (the State's only psychiatric hospital) and the Glencliff Home (a State-owned and -operated nursing facility for people with mental illness)." However, since the report publication, the number of group home beds has diminished. In 2008, the New Hampshire Bureau of Behavioral Health identified 203 residential group home beds available to serve the approximately 7,000 adults with serious and persistent mental illness in New Hampshire.[20] In 2014, the number of residential group home beds available dropped to 177. As part of this Section 1115 Demonstration waiver, the State seeks FFP to add community based residential capacity.

[19] New Hampshire Department of Health and Human Services, Bureau of Behavioral Health Services. "Community Mental Health Services Block Grant Monitoring Report." 4 August 2009. 10 April 2014 <http://www.dhhs.state.nh.us/dcbcs/bbh/documents/monitoring09.pdf>.

[20] New Hampshire Department of Health and Human Services. "Addressing the Critical Mental Health Needs of New Hampshire's Citizens - A Strategy for Restoration: Ten Year Mental Health Plan." 17 September 2008. 10 April 2014 <http://www.dhhs.nh.gov/dcbcs/bbh/documents/restoration.pdf>.

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In December 2013, the New Hampshire Department of Justice entered into a comprehensive settlement agreement, subject to legislative appropriations, of the class action lawsuit, *Amanda D, et al. v. Margaret W. Hassan*[21]. Plaintiffs were represented by counsel including the Disability Rights Center and the U.S. DOJ against the State of New Hampshire on behalf of a class of New Hampshire residents with serious mental illness who are unnecessarily institutionalized in New Hampshire Hospital or Glencliff Nursing Home, or who are at serious risk of unnecessary institutionalization in hospitals, emergency rooms, or prisons. The intention of the comprehensive settlement agreement is to expand and enhance mental health service capacity in integrated community settings within New Hampshire's mental health system. According to the U.S. DOJ Civil Rights Division, "The Agreement will enable a class of adults with serious mental illness to receive needed services in the community, which will foster their independence and enable them to participate more fully in community life. The expanded and enhanced community services will significantly reduce visits to hospital emergency rooms and will avoid unnecessary institutionalization at State mental health facilities, including New Hampshire Hospital ("NHH") (the State's only psychiatric hospital) and the Glencliff Home (a State-owned and -operated nursing facility for people with mental illness).[22]"

New Hampshire seeks FFP for costs not otherwise matchable under Medicaid to enable New Hampshire to implement components of its Ten Year Mental Health Plan and its December 2013 settlement agreement with the U.S. DOJ. The following are central components of the settlement summarized by the Disabilities Rights Center and the U.S. DOJ Civil Rights Division for which the State is seeking FFP. [23, 24]

- *Assertive Community Treatment* - a multi-disciplinary team of professionals that are available around the clock and provide a wide range of flexible services, including case management, medication management, psychiatric services, assistance with employment and housing, substance abuse services, crisis services and other services and supports to allow individuals to live independently in the community. ACT teams are mobile, providing services in individuals' homes and in other community settings[25]. Over the next four years, New Hampshire will expand Assertive Community Treatment teams to ensure they are on call 24 hours a day in all parts of the state. The current State budget appropriates funds to provide 7 day per week coverage. [26]

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[21] *Amanda D, et al. v. Margaret W. Hassan*; United States v. New Hampshire. Civ. No. 1:12-cv-53-SM. United States District Court for the District of New Hampshire. Class Action Settlement Agreement filed 12 February 2014. < http://www.dhhs.state.nh.us/dcbcs/bbh/documents/approved-agreement.pdf>.

[22] U.S. Department of Justice, Civil Rights Division. "New Hampshire ADA Mental Health Settlement Fact Sheet." 8 January 2014. *Amanda D, et al. v. Margaret W. Hassan*; United States v. New Hampshire. Civ. No. 1:12-cv-53-SM. 10 April 2014 <http://www.ada.gov/olmstead/documents/nh-fact-sheet.pdf>.

[23] Disabilities Rights Center, Inc. "Press Release: Federal Judge Approves Class Action Settlement Expanding Mental Health Services." 12 February 2014. 10 April 2014 <http://www.drcnh.org/pressrelease21214judgeissuesfinalorder.pdf>.

[24] U.S. Department of Justice, Civil Rights Division. "New Hampshire ADA Mental Health Settlement Fact Sheet." 8 January 2014. Amanda D., et al. v. Hassan, et al.; United States v. New Hampshire, No. 1:12-CV-53 (SM). 10 April 2014 <http://www.ada.gov/olmstead/documents/nh-fact-sheet.pdf>.

[25] Disabilities Rights Center, Inc. "Press Release: Federal Judge Approves Class Action Settlement Expanding Mental Health Services." 12 February 2014. 10 April 2014 <http://www.drcnh.org/pressrelease21214judgeissuesfinalorder.pdf>.

[26] New Hampshire Department of Justice, Office of the Attorney General. "News Release: Settlement Agreement in Mental Health Services Lawsuit." 19 December 2013. 10 April 2014 <http://doj.nh.gov/media-center/press-releases/2013/20131219-mental-health-settlement.htm>.

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- *Mobile Crisis Teams* – are able to respond to individuals in their homes and communities 24/7 and include access to new crisis apartments, where individuals experiencing a mental health crisis can stay for up to seven days, as an alternative to hospitalization. Under the settlement, New Hampshire will create three mobile crisis teams, with accompanying crisis apartments, to help divert people experiencing mental health crises from emergency rooms and New Hampshire Hospital.
- *Supported Housing* - integrated, scattered-site, permanent housing, coupled with on-going mental health and tenancy support services provided by ACT, case management, and/or a housing specialist. Under the settlement, New Hampshire will expand supported housing opportunities for people with mental illnesses.
- *Quality Assurance and Performance Improvement* - develop and implement a quality assurance and performance improvement system, emphasizing the use of client-level outcome tools and measures to ensure that individuals are provided with sufficient services and supports of good quality to best ensure their health, safety, and welfare. The goal is to help individuals achieve increased independence and greater integration in the community, obtain and maintain stable housing, avoid harms, and decrease the incidence of hospital contacts and institutionalization.
- *Independent Monitor* - an independent monitoring official, called the "Expert Reviewer," who will assess the State's implementation of and compliance with the terms of the Agreement, provide technical assistance when asked, and mediate disputes between and among the parties.

Specifically, DHHS is proposing to use DSHP funding to help implement the activities and services for the State's non-Medicaid population that are not currently matched for FFP. Below is a table of the activities in State Fiscal Year (SFY) 2015 that are not currently matched for FFP. A table with the unmatched funding amount in SFY 2016 to 2018 will be included at a later date in the Appendices.

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Expand and Enhance Mental Health Services: Unmatched Funding Amount in State Fiscal Year (SFY) 2015		
Mental Health Program Name	**Program Source***	**Unmatched Funding Amount in SFY 2015**
ACT - 4 adult teams	10 Year MH Plan	$228,000
ACT - 1 child team	10 Year MH Plan	$70,000
ACT - 5 child teams	10 Year MH Plan	$350,000
ACT - Bring 11 current Adult ACT teams to fidelity	DOJ Settlement	$640,000
ACT - Add 12th & 13th Adult ACT teams	DOJ Settlement	$57,000
Mobile Crisis Teams	DOJ Settlement	$45,000
Community Crisis Apartments	DOJ Settlement	$128,000
Housing Bridge Subsidy Program	10 Year MH Plan	$545,000
Housing Bridge Subsidy Program	DOJ Settlement	$409,000
DRF - Hospital	10 Year MH Plan	$338,000
Residential - 12 beds	10 Year MH Plan	$155,000
Residential - 62 beds	10 Year MH Plan	$50,000
Expand REAP Program	10 Year MH Plan	$75,000
Quality Assurance	DOJ Settlement	$52,000
Expert Reviewer	DOJ Settlement	$88,000
Total		**$3,227,000**

The settlement agreement will provide people with serious mental illness in New Hampshire, both Medicaid and non-Medicaid, with robust community alternatives that will reduce or eliminate the need for hospitalization. The agreement requires the State to create and expand services over the next six years.[27] An independent expert reviewer will evaluate the state's compliance with the agreement and will issue public reports on the state's ongoing implementation efforts. The services included in the settlement agreement are proven, cost-effective measures that lead to recovery and the ability of people with serious mental illness to live successful and fulfilling lives in the community.

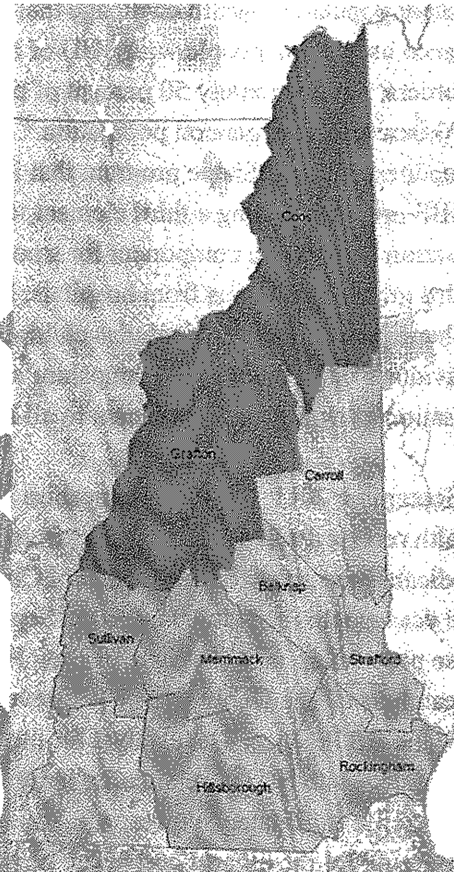
Invest in Substance Use Disorder (SUD) Workforce Development

One of the State's population health focus areas, as outlined in the SHIP, is to address substance misuse by reducing the non-medical use of pain relievers and drug-related overdose deaths in the State. Meeting these goals will require a stronger workforce capable of providing enhanced SUD treatments and services and addressing mental health and SUD comorbidities. To address this need, DHHS proposes a grant program that would fund training education and workforce development programs focused on SUD treatments and services in which hospitals, health systems and/or community providers would apply and DHHS would administer. New Hampshire is experiencing shortages of psychiatrists and other treatment staff. Over one-

[27] U.S. Department of Justice, Office of Public Affairs. News Release: Justice Department Reaches Settlement with State of New Hampshire to Expand Community Mental Health Services and Prevent Unnecessary Institutionalization. 19 December 2013. 12 April 2014 <http://www.justice.gov/opa/pr/2013/December/13-crt-1347.html>.

third of New Hampshire is designated a "mental health professional shortage area" by the Health Resources Services Administration.[29] The map to the right shows the degree of mental health professional shortage area across New Hampshire. According to the Ten Year Mental Health Plan, the availability of adequately trained staff is a significant challenge that directly affects service quality in both inpatient and outpatient settings, in addition to staff wages and staff turnover. This challenge will increase with the advent of a SUD treatment benefit in July 2014 for enrollees in New Hampshire's Health Protection Plan. To access this funding pool, hospitals, health systems and/or community providers will submit proposals for workforce training programs and funding request to DHHS for review and approval.

Degree of Mental Health Professional Shortage by County in New Hampshire[28]



Curriculum components could include, but are not limited to:

- Crisis intervention
- Crisis stabilization
- Emergency Room and related continuum of care
- Related mental health comorbidities
- Neonatal abstinence syndrome (NAS)

The proposed initiative would promote improved access and quality of care for Medicaid beneficiaries in the State by supporting the development of the health care workforce. By using an application approach with providers, this program would incentivize hospitals, health systems, and/or community providers to create and customize SUD health workforce training programs to attract and stabilize their workforce.
This training grant would be administered by DHHS, and payments would be specific to each award. FFP for workforce training programs may be limited to direct and indirect costs. Funding for activities related to this SUD workforce development initiative will be distributed outside of managed care.

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Expand the InShape program

For persons with a persistent and/or severe mental illness staying physically healthy and fit is a special challenge; yet regular exercise and proper diet can be key elements in recovering from a major mental or emotional illness. To address this challenge, New Hampshire has piloted an InShape program that brings the

[28] Health Resources and Services Administration. Health Professional Shortage Area Data Download. 12 April 2014. <http://datawarehouse.hrsa.gov/data/datadownload/hpsaDownload.aspx>.
[29] New Hampshire Department of Health and Human Services. "Addressing the Critical Mental Health Needs of New Hampshire's Citizens - A Strategy for Restoration: Ten Year Mental Health Plan." 17 September 2008. 10 April 2014 <http://www.dhhs.nh.gov/dcbcs/bbh/documents/restoration.pdf>.

benefits of exercise and a healthful way of living to individuals facing these concerns.[30] In order to scale this program further, DHHS proposes expanding components of the InShape program to additional populations. Another population health challenge that this population faces is tobacco use. Specifically, the rate of tobacco use among people with SUD or mental illness is 94 percent higher than among adults without these disorders. Approximately 50 percent of people with mental illnesses and addictions use tobacco, compared to 23 percent of the general population.[31] Therefore, in addition to maintaining the health and wellness component of the InShape program that is focused on improving cardiovascular health by reducing obesity, DHHS proposes adding a third element to the program, which would require the addition of smoking cessation classes as a component for smokers. Specifically, this program would establish a funding pool to award grant applications from hospitals, health systems, and/or community providers to implement an InShape program that (1) includes children with serious mental illness (SMI) as participants, (2) includes individuals enrolled in New Hampshire's 1915(c) HCBS-DD waiver as participants, and (3) offers tobacco cessation as a program component to all InShape participants who smoke.

In September 2011, the New Hampshire Department of Health and Human Services, Bureau of Behavioral Health received a $9.9 million grant from the Centers for Medicare & Medicaid Services to implement a Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) program into its Medicaid program. This five year grant is scheduled to end in September 2016. While being overseen by DHHS, this program runs in close partnership with the State of New Hampshire's ten regional Mental Health Centers and evaluation researchers at The Dartmouth CDC Prevention Research Center and Dartmouth Institute for Health Policy and Clinical Practice. The catalyst for implementing the MIPCD program focuses on health disparities for individuals with SMI. Specifically, individuals receiving public mental health services have a 25 to 30 year reduced life expectancy, representing the greatest health disparity among Medicaid beneficiaries while also accounting for the highest costs. The New Hampshire Medicaid Wellness Incentive Program (WIP) included within MIPCD works to address both the health disparity and increased costs by providing incentivized health promotion programs to overweight or obese and/or tobacco-smoking Medicaid beneficiaries receiving services at New Hampshire's ten regional Community Mental Health Centers (CMHCs).[32] One of these incentivized health programs is InShape, a motivational health-promotion program for persons with mental illness that includes (a) individualized fitness and healthy lifestyle assessment, (b) a fitness plan including eating, exercise, and health-promotion goals, (c) weekly individual meetings with a Health Mentor, (d) access to fitness resources (e.g., YMCA), (e) opportunities for group exercise and healthy eating education, and (f) group motivational "celebrations." The InShape program was initially piloted in New Hampshire in 2004 and has since expanded to most CMHCs in the State as a covered CMH Medicaid benefit. The operation of the program and its recognition by Medicaid was in effect prior to the implementation of the MIPCD. The MIPCD program, however, has since taken this existing program and incentivized its participation via randomized assignments and randomized cash rewards to pay for membership.

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[30] Monadnock Family Services. InShape. n.d. 2 April 2014 <http://www.mfs.org/services/inshape/inshape>.
[31] National Council for Behavioral Health. National Behavioral Health Network for Tobacco & Cancer Control. n.d. 1 April 2014 <http://www.thenationalcouncil.org/consulting-best-practices/national-behavioral-health-network-tobacco-cancer-control/>.
[32] New Hampshire Medicaid Wellness Incentive Program Application and Project Narrative

Under this 1115 Demonstration Waiver, DHHS will expand on the MIPCD program by extending the funding for incentives associated with the InShape program after MIPCD grant funding concludes in September 2016. In addition to extending these incentives, DHHS will expand the populations who can participate in the InShape program, as well as expand the program's scope. Specifically, using DSHP funding, DHHS will expand participation in the InShape program to include children with SMI and to include the 1915(c) HCBS-DD waiver enrollees in the State. There are 9,763 children with serious mental illness (SMI) in the State served by the CMHCs in State Fiscal Year 2013 according to Phoenix Management Information System who could be eligible for an expanded InShape program.

In addition to expanding the InShape program to include these two new populations, DHHS will add smoking cessation classes as a component for participants who smoke. DHHS recognizes the opportunity to address this population health challenge in conjunction with the broader prevention and wellness goals of the InShape program.

Launch Oral Health Pilot Program for Pregnant Women and Mothers of Young Children

DHHS would pilot an expanded Medicaid oral health program for pregnant women and mothers of young children that would accomplish the following:

- Establish an education program for all mothers to increase the understanding and value of oral health
- Encourage participation by all mothers who smoke in an approved smoking cessation program
- Establishes a benefit that provides coverage for dental services to all mothers during pregnancy *until their child's fifth birthday*
    - This will include mothers over 21 years of age who are not currently eligible for any Medicaid dental services
    - This will include mothers under 21 years of age who are currently eligible for Medicaid dental services until they turn 21 or otherwise 60 days postpartum

Scope of dental benefits will include comprehensive and periodic dental examinations, periodontal services as indicated, restorative and limited prosthetic dental treatment, and extractions if medically necessary for women who participate by meeting certain compliance goals that include but are not limited to:

- Scheduling and completing a dentist's annual examination and cleaning (including scaling/root planning if needed);
- Participating in smoking cessation;
- Taking child to annual dental checkup beginning before age one;
- Returning annual surveys to report success with smoking cessation;
- Compliance with recommended dental treatment;
- Changes in understanding of oral health, attitude shifts, etc.

Program rewards and incentives would be provided to women and children who meet certain performance criteria developed by DHHS. Women would have an opportunity to participate in the pilot program and its

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evaluation study, or elect not to participate. Non-participants would be eligible for the same dental services provided through the benefit mentioned above, and would receive the same education information provided to all mothers.

Dental services provided through the benefit to clients before they transition to MCM will be paid on a Fee-For-Service basis. When dental services are provided through the benefit to clients enrolled with one of New Hampshire's MCOs, the MCO will be required by contract to reimburse for dental services for these eligibility groups. An actuarially sound rate will be developed and amended contract language will require payments for dental services.

Section III – Impact of Demonstration on State's current Medicaid and CHIP programs

Impact of Demonstration on Eligibility

New Hampshire is not requesting any changes in Medicaid program eligibility through this Section 1115 Demonstration Waiver. Coverage for groups of individuals currently covered under the state's Medicaid and CHIP State plans, previous waiver programs, and previously state-funded programs will continue. Therefore, there is no anticipated impact on total Medicaid enrollment as a result of these proposed DSHPs. Nonetheless, DHHS anticipates that current and newly expanded Medicaid beneficiaries in general will experience:

- Increased access to certain services, such as mental health and SUD, oral health, and health and wellness services
- Improvements in the way their services are delivered at hospitals, health systems and community providers

Impact of Demonstration on Benefits and Cost Sharing Requirements

Through its *Building Capacity for Transformation* Section 1115 Demonstration Waiver, New Hampshire proposes to offer Medicaid dental benefits to women who are pregnant until their child's fifth birthday. Pregnant women under 21 years of age will continue to be eligible for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) dental services. Dental services for pregnant women and mothers of young children through the benefit will differ from those provided under the Medicaid and/or CHIP State plan. Scope of dental services within the benefit will include comprehensive and periodic dental examinations, periodontal services as indicated, restorative and limited prosthetic dental treatment, and extractions if medically necessary.

The cost sharing requirements under the Demonstration will not differ from those provided under the Medicaid and/or CHIP State plan. Copayments, coinsurance and/or deductibles will not differ from the Medicaid State plan.

Since the dental health benefit package will apply to different eligibility groups affected by the Demonstration, the chart below specifying the benefit package that each eligibility group will receive under

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the Demonstration.

New Hampshire Department of Health and Human Services	
Benefit Package Chart	
Eligibility Group*	Benefit Package*
Pregnant women and mothers of young children *who are currently not eligible for EPSDT dental benefits*	Demonstration-only Dental Benefit

*Description of Eligibility Group and/or Benefit Package is subject to change

The Benefit Specifications and Qualifications form and related Benefit Charts will be included at a later date in the Appendices for benefits that differ from the Medicaid or CHIP State plan.

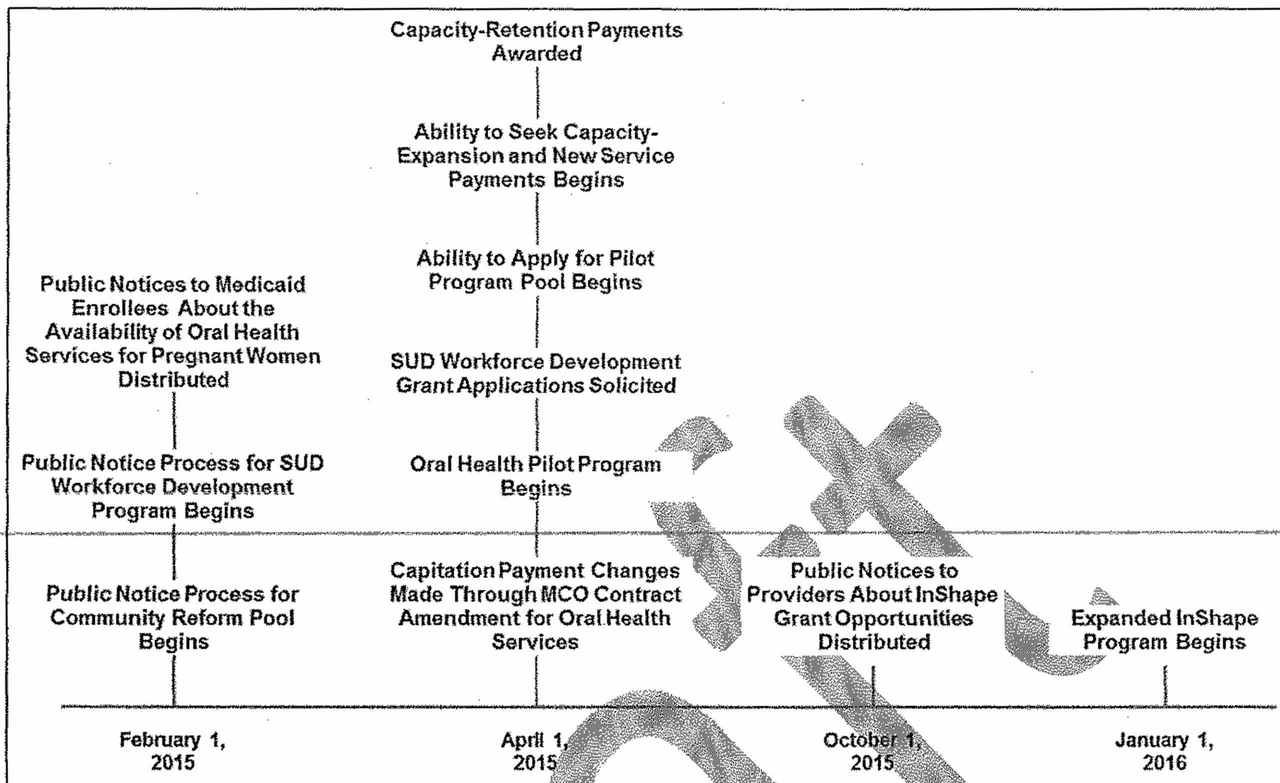
Please note that long term services and supports (LTSS) will not be provided and premium assistance for employer sponsored coverage will not be available through this *Building Capacity for Transformation* Section 1115 Demonstration Waiver.

Section IV – Delivery System of Demonstration

The delivery system used to provide benefits to Demonstration participants will not differ from the Medicaid and/or CHIP State plan. The State of New Hampshire enrolls the majority of its Medicaid beneficiaries on a mandatory basis into MCOs under its Section 1932 State Plan Amendment (12-006) effective September 2012 and will eventually include all Medicaid beneficiaries. A table depicting the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration will be included at a later date in the Appendices. This also includes the appropriate authority that is currently authorized under the State plan and/or section 1932 option.

Section V – Implementation of Demonstration

Below is the draft implementation schedule for the Demonstration Waiver, including dates by major component. Dates are subject to change and are contingent on approval from CMS.



MCOs will provide oral health benefits and InShape services as described in this Demonstration Waiver. Capitation payment changes will be made on April 1, 2015 through a contract amendment. All other payments will be made outside of MCM.

During and after initial waiver approval from CMS, New Hampshire will collaborate with providers and CMS to finalize the community reform pool, SUD workforce development and provider pilot grant pools, and select projects and associated milestones within a mutually acceptable timeline.

Section VI – Demonstration Financing and Budget Neutrality

New Hampshire will maintain budget neutrality over the five-year lifecycle of this Section 1115 Demonstration Waiver, with total spending under the waiver not exceeding what the federal government would have spent without the waiver. The budget neutrality approach is still under development, but is likely to follow the basic approach described below:

- The baseline historical data will include five full years of New Hampshire Medicaid expenditures derived from CMS-64 reports and related enrollment data from calendar year (CY) 2008 to CY 2012
- The projected "without waiver" expenditures will reflect the following changes between the baseline and waiver periods:
    - Enrollment trends, reflecting any anticipated trend differences by eligibility category (e.g., low income children and families, Medicaid-only disabled, and dual eligibles)

    - Medical service trends
    - Impact of known program changes (e.g., the impact of the Department of Justice settlement on behavioral health services)
    - Excludes the impact of New Hampshire's Medicaid Care Management program that was implemented on December 1, 2013
- The projected expenditures under the proposed 1115 waiver will reflect the following changes to the "without waiver" projections:
    - Managed care savings resulting from the December 1, 2013 implementation of the Medicaid Care Management program for acute care services (i.e., "Step 1" services) and future implementation of care management for long term services and supports (LTSS)
    - Trend differences due to Medicaid Care Management program implementation
    - The estimated net financial impact of the proposed Designated State Health Program (DSHP) services included in the 1115 waiver, considering both the increased costs related to the new services, payment enhancements, and incentives, as well as offsetting savings to the system such as:
        - Expanding New Hampshire's mental health infrastructure is expected to reduce preventable inpatient mental health admissions and readmissions and reduce other acute care costs because mental health and substance use disorder conditions will be better managed
        - The DSHP oral health program for pregnant women and mothers is expected to reduce occurrences of young children and their mothers hospitalized for emergency dental treatment as well as reduce incidences of low birth weight babies and babies born with complications.

Note: With the exception of matching the state funds associated with services included in the State's Ten Year Mental Health Plan provided to non-Medicaid enrollees, the programs described in this application could be approved by amending New Hampshire's State Plan.

A description of the Budget Neutrality methodology and the Budget Neutrality Spreadsheet will be included at a later date in the Appendices.

Section VII – List of Proposed Waivers and Expenditure Authorities

Federal Waivers, Expenditure and Cost Not Otherwise Matchable Authorities Requested

New Hampshire seeks federal financial participation for costs not otherwise matchable under Medicaid to enable New Hampshire to implement the Designated State Health Programs (DSHPs) under this 1115 Demonstration. Under the authority of Section 1115(a)(2) of the Social Security Act, expenditures made by the State for the items identified below, which are not otherwise included as expenditures under Section 3, 455, 1003, 1403, 1603, or 1903, shall, for the period of this demonstration, be regarded as expenditures under the Medicaid.

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- Costs incurred by DHHS for Glencliff Home, New Hampshire Hospital, and Sununu Youth Services Center
- Costs incurred by DHHS for activities stemming from the Ten Year Mental Health Plan and Settlement
- Costs incurred by the Department of Corrections for health care
- Correctional medical/health costs incurred by counties
- Health care expenditures incurred by municipalities

The potential sources for match are included in *Attachment A. Summary of Potential DSHP Resources.* Please note it is a preliminary list of DSHP funding sources. DHHS is in the process of identifying a complete list of sources that would be eligible for federal matching funds and inclusion in the DSHP proposals described above.

CMS and the State will identify any other waivers and expenditure authorities needed to implement this waiver.

Legislative Authority

As the single state agency responsible for the administration of Medicaid in New Hampshire, the Department of Health and Human Services is given broad authority by the New Hampshire Legislature to seek waivers in the Medicaid program. Additionally, the New Hampshire Legislature passed specific legislation in 2014 requiring DHHS to implement an 1115 Demonstration Waiver as described in this proposal. SB 413-FN-A, an act relative to access to health insurance coverage, was signed into law by Governor Maggie Hassan on March 27, 2014.

Section VIII – Stakeholder Engagement and Public Notice

As part of the stakeholder engagement process required within the development of this Section 1115 Demonstration Waiver, the State is seeking consultation with stakeholders including state, county, and local officials and health care providers.

DHHS will gather stakeholder input through a required public notice process that includes two required public hearings and a dedicate website. The website for public information on this Section 1115 Demonstration Waiver is http://www.dhhs.nh.gov/section-1115-waiver/index.htm. The web page will include a copy of the waiver concept paper, waiver draft, materials from stakeholder meetings (once available), and instructions (with links) on how to submit comments on waiver application draft.

The public comment period for New Hampshire's proposed Section 1115 Demonstration Waiver is from Monday, April 21, 2014 until Tuesday, May 20, 2014 at 5 p.m. (Eastern). Comments received within 30 days of the posting of this notice will be reviewed and considered for revisions to the Section 1115 Demonstration Waiver application. Two public hearings on the proposed Section 1115 Demonstration Waiver are scheduled to solicit input on the proposed enhancements to the Medicaid program. The State will

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accept verbal and/or written comments at the public hearings. The dates for the public hearings are May 8, 2014 and May 12, 2014.

As part of the state's oversight of its Medicaid Care Management (MCM) program, Governor Hassan established a commission that brings together members of the public representing a broad range of experience in health care issues to review and advise on the implementation of an efficient, fair and high-quality Medicaid care management system.[33] The Governor's Commission on Medicaid Care Management is being actively engaged in the development of this Section 1115 Demonstration Waiver application. Specifically, the second public hearing will be held in conjunction with a meeting of the Governor's Commission on Medicaid Care Management.

The state legislature is significantly involved in the development of this waiver. This process formally began on March 27, 2014 when SB413 was signed into law requiring DHHS to submit a statewide Section 1115 Demonstration Waiver by June 1, 2014. DHHS meets regularly with legislative leadership in both informal and formal venues, including the legislature's Fiscal Committee. This waiver application will be presented to, reviewed by, and approved by the legislature's Fiscal Committee before its submission to CMS.

During and after approval from CMS, the State will continue to seek stakeholder input in standing up each DSHP program and conduct a robust engagement process to spread awareness about these system improvements.

Section IX – Demonstration Administration

The contact information for the state's point of contact for the Demonstration application is below.

Name and Title: Jeffrey A. Meyers, Director, Intergovernmental Affairs
New Hampshire Department of Health and Human Services

Please email 1115waiver@dhhs.state.nh.us to submit comments regarding the New Hampshire Department of Health and Human Services *Building Capacity for Transformation* Section 1115 Demonstration Waiver.

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[33] State of New Hampshire. "Press Release: Governor Hassan Issues Executive Order Creating Commission on Medicaid Care Management." 10 April 2013. 2 April 2014 <http://www.governor.nh.gov/media/news/2013/pr-2013-04-10-medicaid-care.htm>.

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Section X – Appendices

Attachment A: Resources for Costs Not Otherwise Matchable / Designated State Health Programs

The State of New Hampshire identified the following State and locally funded health programs that may qualify for federal financial participation (FFP).

State of New Hampshire Health Care Funding Summary of Potential Designated State Health Program (DSHP) Resources*	
Funding Sources	**Funding Amount**
State Funding Sources	
Department of Health and Human Services SFY 2015 Biennial Budget:	
Glencliff Home General Funds	$7,544,949
New Hampshire Hospital General Funds	$24,650,441
Sununu Youth Services Center General Funds	$14,683,277
Department of Health and Human Services Ten Year Mental Health Plan/DOJ Settlement	$3,227,000
Department of Corrections SFY 2015 Biennial Budget for Medical and Dental Services	$10,760,687
State Funding Sources Total	**$60,866,354**
Municipality Funding Sources	
2013 Report of Appropriations Actually Voted (M-2 Form) reported to the Department of Revenue Administration	
Health Administration	$4,320,521
Health Agencies & Hosp. & Other	$7,367,123
Municipality Funding Sources Total	**$11,687,644**
County Funding Sources	
Correctional Medical/Health Spending	$6,093,757
County Funding Sources Total	**$6,093,757**
Grand Total	**$78,647,755**

**Please note that this list of unmatched health care funding only reflects potential sources for DSHP match and has not yet been reviewed and analyzed sufficiently to determine whether all the funds are potentially useable for DSHP matching purposes.*

Attachment B: Supporting Medicaid Claims Data Analyses for Designated State Health Programs

New Hampshire Department of Health and Human Services
Cost by Category of Service for Beneficiaries Receiving Mental Health/SUD Screening and Treatment Services
In State Fiscal Year 2012 for children under the age of 19 years

Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Hospital Inpatient								
Medical	561	$3,395,992	739	5,474	38.5	285.4	$620.39	$14.75
Surgical	119	1,129,372	126	905	6.6	47.2	1,247.92	4.91
Maternity Delivery	142	267,460	142	447	7.4	23.3	598.34	1.16
Maternity Non-Delivery	13	32,534	19	101	1.0	5.3	322.12	0.14
Newborn	23	10,822	23	66	1.2	3.4	163.97	0.05
Psychiatric	451	6,176,041	668	5,947	34.8	310.0	1,038.51	26.83
Alcohol and Drug Abuse	4	5,584	4	3	0.2	0.2	1,861.47	0.02
Crossover	0	0	0	0	0.0	0.0	0.00	0.00
Other	18	837,235	117	1,687	6.1	87.9	496.29	3.64
		$11,855,039	1,838	14,630	95.8	762.7	$810.32	$51.50
Skilled Nursing Facility	0	$0	0	0	0.0	0.0	$0.00	$0.00
Hospital Outpatient								
Emergency Room	8,164	$2,228,663	0	21,964	0.0	1,145.1	$101.47	$9.68
Surgery	1,507	2,286,447	0	60,413	0.0	3,149.6	37.85	9.93
Radiology	5,911	1,981,109	0	13,050	0.0	680.3	151.81	8.61
Pathology/Lab	8,764	771,119	0	90,933	0.0	4,740.7	8.48	3.35
Pharmacy	5,100	492,450	0	71,949	0.0	3,751.0	6.84	2.14
Cardiovascular	945	200,156	0	1,675	0.0	87.3	119.50	0.87
PT/OT/ST	1,115	1,190,413	0	43,728	0.0	2,279.7	27.22	5.17
Psychiatric	0	0	0	0	0.0	0.0	0.00	0.00
Alcohol & Drug Abuse	0	0	0	0	0.0	0.0	0.00	0.00
Crossover	0	0	0	0	0.0	0.0	0.00	0.00

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New Hampshire Department of Health and Human Services
Cost by Category of Service for Beneficiaries Receiving Mental Health/SUD Screening and Treatment Services
In State Fiscal Year 2012 for children under the age of 19 years

Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Other	4,693	1,062,007	0	37,457	0.0	1,952.8	28.35	4.61
		$10,212,364	0	341,169	0.0	17,786.4	$29.93	$44.37
Professional								
Ambulatory Surgery Center	266	$136,284	0	382	0.0	19.9	$356.76	$0.59
Physician	18,330	7,503,837	0	231,011	0.0	12,043.5	32.48	32.60
Advance Registered Nurse Practitioner	325	85,995	0	2,249	0.0	117.2	38.24	0.37
Certified Midwife	2	2,067	0	16	0.0	0.8	129.18	0.01
Family Planning	306	46,279	0	1,713	0.0	89.3	27.02	0.20
Audiology	115	9,385	0	1,065	0.0	55.5	8.81	0.04
Psychology	5,203	3,718,095	0	59,677	0.0	3,111.2	62.30	16.15
Physical Therapy	302	229,244	0	11,064	0.0	576.8	20.72	1.00
Speech Therapy	308	303,186	0	16,911	0.0	881.6	17.93	1.32
Occupational Therapy	334	394,717	0	19,474	0.0	1,015.3	20.27	1.71
Podiatry	145	20,751	0	534	0.0	27.8	38.86	0.09
Laboratory	1,275	218,197	0	26,884	0.0	1,401.6	8.12	0.95
X-Ray	358	47,502	0	863	0.0	45.0	55.04	0.21
Clinic Services	3,960	21,858,284	0	8,497,328	0.0	442,997.9	2.57	94.96
Methadone Treatment Clinic	11	12,192	0	1,193	0.0	62.2	10.22	0.05
Medical Services Clinic	135	25,270	0	943	0.0	49.2	26.80	0.11
Federally Qualified and Rural Health Clinics	3,852	2,145,724	0	18,066	0.0	941.8	118.77	9.32
Other	0	0	0	0	0.0	0.0	0.00	0.00
		$36,757,011	0	8,889,373	0.0	463,436.7	$4.13	$159.69
Mental Health Center								
Case Management	5,958	$13,026,486	0	36,383	0.0	1,896.8	$358.04	$56.59
Long Term Support Service	3,612	10,042,189	0	433,016	0.0	22,574.8	23.19	43.63

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New Hampshire Department of Health and Human Services
Cost by Category of Service for Beneficiaries Receiving Mental Health/SUD Screening and Treatment Services
In State Fiscal Year 2012 for children under the age of 19 years

Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Partial Hospital	31	94,995	0	1,015	0.0	52.9	93.59	0.41
Psychotherapy	7,452	8,022,894	0	183,820	0.0	9,583.2	43.65	34.86
Evidence Based Practice	29	32,289	0	1,247	0.0	65.0	25.89	0.14
Medication Management	1,382	241,797	0	5,443	0.0	283.8	44.42	1.05
Emergency Service 24/7	132	32,727	0	1,395	0.0	72.7	23.46	0.14
APRTP	9	47,214	0	86	0.0	4.5	549.00	0.21
Other	2,657	1,046,026	0	10,509	0.0	547.9	99.54	4.54
		$32,586,615	0	672,914	0.0	35,081.6	$48.43	$141.57
Prescription Drugs								
Generic Scripts	16,161	$2,662,624	0	151,396	0.0	7,892.8	$17.59	$11.57
Single Source Brand	11,173	19,540,768	0	92,145	0.0	4,803.9	212.07	84.89
Multi-Source Brand	782	859,616	0	3,124	0.0	162.9	275.17	3.73
Other	1,494	480,384	0	3,401	0.0	177.3	141.25	2.09
		$23,543,392	0	250,066	0.0	13,036.9	$94.15	$102.28
Other Services								
Home Health	520	$3,131,764	0	503,305	0.0	26,239.2	$6.22	$13.61
Hospice	0	0	0	0	0.0	0.0	0.00	0.00
Durable Medical Equipment	1,708	2,296,005	0	1,788,267	0.0	93,229.1	1.28	9.97
Ambulance	1,129	351,341	0	26,332	0.0	1,372.8	13.34	1.53
Wheelchair Van	10	6,195	0	1,373	0.0	71.6	4.51	0.03
Optometry / Glasses	4,352	435,788	0	27,121	0.0	1,413.9	16.07	1.89
Private Duty Nursing	16	803,990	0	20,518	0.0	1,069.7	39.18	3.49
Personal Care	1	39,678	0	9,059	0.0	472.3	4.38	0.17
Adult Medical Day Care	1	3,398	0	69	0.0	3.6	49.24	0.01
Home and Community Based Care: DI	701	5,268,985		259,505		13,529.0	20.30	22.89
Home and Community Based	1	2,813		541		28.2	5.20	0.01

Draft

New Hampshire Department of Health and Human Services Cost by Category of Service for Beneficiaries Receiving Mental Health/SUD Screening and Treatment Services In State Fiscal Year 2012 for children under the age of 19 years								
Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Care: CI Other	14,947	25,235,495	0	367,302	0.0	19,148.8	68.71	109.64
		$37,575,452	0	3,003,392	0.0	156,578.2	$12.51	$163.25
All Services		$152,529,872	1,838	13,171,544	95.8	686,682.5	$999.48	$662.66

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New Hampshire Department of Health and Human Services
Cost by Category of Service for Beneficiaries Receiving Mental Health/SUD Screening and Treatment Services
In State Fiscal Year 2012 for Adults over the age of 20 years

Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Hospital Inpatient								
Medical	1,736	$9,688,910	2,993	15,475	124.8	645.1	$626.10	$33.66
Surgical	728	6,544,121	849	5,722	35.4	238.5	1,143.68	22.74
Maternity Delivery	1,201	2,496,209	1,202	3,387	50.1	141.2	737.00	8.67
Maternity Non-Delivery	144	335,040	191	617	8.0	25.7	543.02	1.16
Newborn	1	467	1	3	0.0	0.1	155.71	0.00
Psychiatric	526	2,295,066	712	4,799	29.7	200.1	478.24	7.97
Alcohol and Drug Abuse	165	465,140	219	947	9.1	39.5	491.17	1.62
Crossover	3,834	7,909,243	5,625	45,644	234.5	1,902.9	173.28	27.48
Other	4,704	156,650,705	73,501	1,239,767	3,064.2	51,685.3	126.35	544.22
		$186,384,900	85,293	1,316,361	3,555.8	54,878.5	$141.59	$647.53
Skilled Nursing Facility	657	$2,691,369	1,384	25,457	57.7	1,061.3	$105.72	$9.35
Hospital Outpatient								
Emergency Room	12,389	$4,968,391	0	47,440	0.0	1,977.8	$104.73	$17.26
Surgery	3,421	5,003,763	0	133,416	0.0	5,562.1	37.50	17.38
Radiology	15,997	9,829,767	0	57,775	0.0	2,408.6	170.14	34.15
Pathology/Lab	19,630	3,551,704	0	283,852	0.0	11,833.7	12.51	12.34
Pharmacy	14,946	9,376,110	0	692,447	0.0	28,867.8	13.54	32.57
Cardiovascular	4,761	909,867	0	9,890	0.0	412.3	92.00	3.16
PT/OT/ST	3,837	1,131,848	0	38,312	0.0	1,597.2	29.54	3.93
Psychiatric	84	9,509	0	252	0.0	10.5	37.73	0.03
Alcohol & Drug Abuse	0	0	0	0	0.0	0.0	0.00	0.00
Crossover	7,790	1,510,431	0	39,339	0.0	1,640.0	38.40	5.25
Other	8,782	4,100,528	0	103,439	0.0	4,312.3	39.64	14.25
		$40,391,918	0	1,406,162	0.0	58,622.2	$28.72	$140.33
Professional								

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New Hampshire Department of Health and Human Services
Cost by Category of Service for Beneficiaries Receiving Mental Health/SUD Screening and Treatment Services
In State Fiscal Year 2012 for Adults over the age of 20 years

Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Ambulatory Surgery Center	1,394	$803,213	0	4,243	0.0	176.9	$189.30	$2.79
Physician	29,825	21,798,053	0	1,043,062	0.0	43,484.8	20.90	75.73
Advance Registered Nurse Practitioner	1,118	186,143	0	7,360	0.0	306.8	25.29	0.65
Certified Midwife	10	11,058	0	90	0.0	3.8	122.87	0.04
Family Planning	721	487,232	0	5,576	0.0	232.5	87.38	1.69
Audiology	91	3,955	0	292	0.0	12.2	13.55	0.01
Psychology	2,990	1,469,708	0	27,579	0.0	1,149.8	53.29	5.11
Physical Therapy	1,079	506,447	0	28,577	0.0	1,191.4	17.72	1.76
Speech Therapy	12	9,989	0	614	0.0	25.6	16.27	0.03
Occupational Therapy	97	17,149	0	1,268	0.0	52.9	13.52	0.06
Podiatry	2,163	111,005	0	5,682	0.0	236.9	19.54	0.39
Laboratory	3,683	438,216	0	48,566	0.0	2,024.7	9.02	1.52
X-Ray	3,581	423,515	0	13,713	0.0	571.7	30.88	1.47
Clinic Services	278	1,358,225	0	478,438	0.0	19,945.9	2.84	4.72
Methadone Treatment Clinic	1,362	3,191,303	0	312,294	0.0	13,019.4	10.22	11.09
Medical Services Clinic	129	50,966	0	1,282	0.0	53.4	39.76	0.18
Federally Qualified and Rural Health Clinics	7,256	4,329,604	0	43,864	0.0	1,828.7	98.71	15.04
Other	0	0	0	0	0.0	0.0	0.00	0.00
		$35,195,782	0	2,022,500	0.0	84,317.1	$17.40	$122.27
Mental Health Center								
Case Management	6,885	$17,118,622	0	53,982	0.0	2,250.5	$317.12	$59.47
Long Term Support Service	5,976	27,572,908	0	936,324	0.0	39,034.9	29.45	95.79
Partial Hospital	235	2,283,957	0	23,726	0.0	989.1	96.26	7.93
Psychotherapy	8,233	4,111,131	0	121,610	0.0	5,069.9	33.81	14.28
Evidence Based Practice	2,001	2,871,585	0	122,651	0.0	5,113.3	23.41	9.98
Medication Management	6,471	1,118,090	0	37,098	0.0	1,546.6	30.14	3.88

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New Hampshire Department of Health and Human Services
Cost by Category of Service for Beneficiaries Receiving Mental Health/SUD Screening and Treatment Services
In State Fiscal Year 2012 for Adults over the age of 20 years

Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Emergency Service 24/7	1,089	452,998	0	19,398	0.0	808.7	23.35	1.57
APRTP	3,177	1,778,380	0	14,346	0.0	598.1	123.96	6.18
Other	6,578	1,280,047	0	26,970	0.0	1,124.4	47.46	4.45
		$58,587,717	0	1,356,105	0.0	56,535.4	$43.20	$203.54
Prescription Drugs								
Generic Scripts	23,821	$7,067,595	0	532,652	0.0	22,206.0	$13.27	$24.55
Single Source Brand	10,847	31,561,567	0	110,008	0.0	4,586.2	286.90	109.65
Multi-Source Brand	1,723	4,868,404	0	10,889	0.0	454.0	447.09	16.91
Other	6,913	935,366	0	40,497	0.0	1,688.3	23.10	3.25
		$44,432,932	0	694,046	0.0	28,934.5	$64.02	$154.37
Other Services								
Home Health	1,709	$3,359,431	0	288,766	0.0	12,038.5	$11.63	$11.67
Hospice	0	0	0	0	0.0	0.0	0.00	0.00
Durable Medical Equipment	7,361	5,489,738	0	3,099,299	0.0	129,208.3	1.77	19.07
Ambulance	7,017	1,560,991	0	93,716	0.0	3,907.0	16.66	5.42
Wheelchair Van	2,252	1,945,420	0	335,201	0.0	13,974.4	5.80	6.76
Optometry / Glasses	6,724	625,634	0	37,874	0.0	1,578.9	16.52	2.17
Private Duty Nursing	10	585,909	0	15,906	0.0	663.1	36.84	2.04
Personal Care	87	2,720,624	0	621,147	0.0	25,895.3	4.38	9.45
Adult Medical Day Care	184	767,083	0	32,467	0.0	1,353.5	23.63	2.66
Home and Community Based Care: DI	1,940	121,692,830		6,395,970		266,645.0	19.03	422.78
Home and Community Based Care: CI	2,148	31,113,551		4,177,909		174,175.1	7.45	108.09
Other	6,075	3,720,794	0	66,790	0.0	2,784.4	55.71	12.93
		$173,582,005	0	15,165,045	0.0	632,223.7	$11.45	$603.05
All Services		$541,266,623	86,677	21,985,676	3,613.5	916,572.7	$412.11	$1,880.43

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New Hampshire Department of Health and Human Services Cost of Hospital Outpatient Visits for Claims with Mental Health/SUD Diagnoses								
State Fiscal Year	Total Allowed	Total Paid	Total Visits	Unique Beneficiaries	Visits per Unique Beneficiary	Visits per Total Beneficiary	Allowed Cost per Visit	Paid Cost per Visit
SFY10/11	11,056,068	11,808,999	46,418	19,066	2.43	0.86	238.18	254.41
SFY11/12	12,402,076	13,207,186	47,644	19,337	2.46	0.87	260.31	277.21

The data includes a significant number of facility claims with allowed = $0, but non-zero paid amount.

New Hampshire Department of Health and Human Services ER Visits for Claims with Mental Health/SUD Diagnoses						
State Fiscal Year	Total Allowed	Total Paid	Total Visits	Unique Beneficiaries	Allowed Cost per Visit	Paid Cost per Visit
SFY10/11	1,795,246	2,045,237	15,546	9,018	115.48	131.56
SFY11/12	2,107,373	2,318,151	15,223	8,786	138.43	152.28

Emergency Room Visits defined as claims with Revenue Code 450.
The data includes a significant number of facility claims with allowed = $0, but non-zero paid amount.

New Hampshire Department of Health and Human Services Psychiatric Admissions for Claims with Mental Health/SUD Diagnoses						
State Fiscal Year	Total Allowed	Total Paid	Total Admissions	Unique Beneficiaries	Allowed Cost per Admit	Paid Cost per Admit
SFY10/11	2,365,557	$2,303,181	872	632	$2,712.80	$2,641.26
SFY11/12	2,158,261	$2,099,939	816	622	$2,644.93	$2,573.45

New Hampshire Department of Health and Human Services Inpatient and Outpatient Expenditures by Provider for Claims with Mental Health/SUD Diagnoses in State Fiscal Year 2012				
Count of Provider IDs	Allowed Amounts		Paid Amounts	
	Inpatient	Outpatient	Inpatient	Outpatient
271	$145,791,763	$12,199,524	$121,305,893	$13,002,116

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New Hampshire Department of Health and Human Services
Beneficiaries with Delivery Codes by Age

State Fiscal Year	Age Category	Total Beneficiaries	Percent by Age Category
SFY10/11	< 21	919	21%
SFY10/11	>= 21	3,409	79%
SFY10/11	All	4,328	
SFY11/12	< 21	766	19%
SFY11/12	>= 21	3,306	81%
SFY11/12	All	4,072	

New Hampshire Department of Health and Human Services
Cost of Dental Services for Maternity Beneficiaries Under the Age of 21 Years

State Fiscal Year	Unique Beneficiaries	Total Allowed	Total Paid	Total Services	Allowed Cost per Service	Paid Cost per Service
FY10/11	301	150,875	151,787	2,121	71.13	71.56
FY11/12	249	119,842	122,454	1,951	61.43	62.76

Dental Services are identified as having a diagnostic code 520-526 or CPT codes starting with D.

The data includes a significant number of facility claims with allowed = $0, but non-zero paid amount.

New Hampshire Department of Health and Human Services
Cost of Emergency Dental Services for Maternity Beneficiaries Over the Age of 21 Years

State Fiscal Year	Unique Beneficiaries	Total Allowed	Total Paid	Total Services	Allowed Cost per Service	Paid Cost per Service
SFY10/11	195	19,506	24,181	329	59.29	73.50
SFY11/12	172	19,446	23,526	278	69.95	84.63

Dental Services are identified as having a diagnostic code 520-526 and a 450 Revenue Code.

The data includes a significant number of facility claims with allowed = $0, but non-zero paid amount.

New Hampshire Department of Health and Human Services
Cost Model for Newborns that are Pre-Term or Low Birth Weight
Services Received in the First Month After Birth
In State Fiscal Year 2012

Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Hospital Inpatient								
Medical	560	$6,358,166	663	9,190	850.0	11,782.1	$691.86	$8,151.49
Surgical	11	422,401	11	667	14.1	855.1	633.29	541.54
Maternity Delivery	0	0	0	0	0.0	0.0	0.00	0.00
Maternity Non-Delivery	0	0	0	0	0.0	0.0	0.00	0.00
Newborn	157	73,670	157	391	201.3	501.3	188.41	94.45
Psychiatric	0	0	0	0	0.0	0.0	0.00	0.00
Alcohol and Drug Abuse	0	0	0	0	0.0	0.0	0.00	0.00
Crossover	1	2,906	1	7	1.3	9.0	415.07	3.73
Other	0	0	0	0	0.0	0.0	0.00	0.00
		$6,857,142	832	10,255	1,067	13,147.4	$668.66	$8,791.21
Skilled Nursing Facility	0	$0	0	0	0	0.0	$0.00	$0.00
Hospital Outpatient								
Emergency Room	45	$7,221	0	72	0.0	92.3	$100.30	$9.26
Surgery	3	304	0	3	0.0	3.8	101.29	0.39
Radiology	37	4,341	0	42	0.0	53.8	103.35	5.56
Pathology/Lab	101	2,171	0	386	0.0	494.9	5.62	2.78
Pharmacy	14	1,263	0	61	0.0	78.2	20.71	1.62
Cardiovascular	5	2,484	0	19	0.0	24.4	130.75	3.18
PT/OT/ST	4	176	0	4	0.0	5.1	44.11	0.23
Psychiatric	0	0	0	0	0.0	0.0	0.00	0.00
Alcohol & Drug Abuse	0	0	0	0	0.0	0.0	0.00	0.00
Crossover	0	0	0	0	0.0	0.0	0.00	0.00
Other	43	6,095	0	147	0.0	188.5	41.46	7.81
		$24,056	0	734	0.0	941.0	$32.77	$30.84
Professional								
Ambulatory Surgery Center	0	$0	0	0	0.0	0.0	$0.00	$0.00

Draft

New Hampshire Department of Health and Human Services
Cost Model for Newborns that are Pre-Term or Low Birth Weight
Services Received in the First Month After Birth
In State Fiscal Year 2012

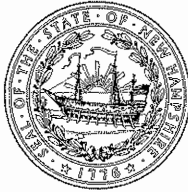
Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Physician	749	872,032	0	12,339	0.0	15,819.2	70.67	1,117.99
Advance Registered Nurse Practitioner	0	0	0	0	0.0	0.0	0.00	0.00
Certified Midwife	2	1,032	0	14	0.0	17.9	73.70	1.32
Family Planning	1	40	0	1	0.0	1.3	40.00	0.05
Audiology	1	22	0	7	0.0	9.0	3.11	0.03
Psychology	0	0	0	0	0.0	0.0	0.00	0.00
Physical Therapy	0	0	0	0	0.0	0.0	0.00	0.00
Speech Therapy	0	0	0	0	0.0	0.0	0.00	0.00
Occupational Therapy	0	0	0	0	0.0	0.0	0.00	0.00
Podiatry	0	0	0	0	0.0	0.0	0.00	0.00
Laboratory	0	0	0	0	0.0	0.0	0.00	0.00
X-Ray	0	0	0	0	0.0	0.0	0.00	0.00
Clinic Services	6	607	0	39	0.0	50.0	15.56	0.78
Methadone Treatment Clinic	0	0	0	0	0.0	0.0	0.00	0.00
Medical Services Clinic	3	579	0	15	0.0	19.2	38.62	0.74
Federally Qualified and Rural Health Clinics	149	49,079	0	468	0.0	600.0	104.87	62.92
Other	0	0	0	0	0.0	0.0	0.00	0.00
		$923,391	0	12,883	0.0	16,516.7	$71.68	$1,183.83
Mental Health Center								
Case Management	0	$0	0	0	0.0	0.0	$0.00	$0.00
Long Term Support Service	0	0	0	0	0.0	0.0	0.00	0.00
Partial Hospital	0	0	0	0	0.0	0.0	0.00	0.00
Psychotherapy	0	0	0	0	0.0	0.0	0.00	0.00
Evidence Based Practice	0	0	0	0	0.0	0.0	0.00	0.00
Medication Management	0	0	0	0	0.0	0.0	0.00	0.00
Emergency Service 24/7	0	0	0	0	0.0	0.0	0.00	0.00

Draft

New Hampshire Department of Health and Human Services
Cost Model for Newborns that are Pre-Term or Low Birth Weight
Services Received in the First Month After Birth
In State Fiscal Year 2012

Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
APRTP	0	0	0	0	0.0	0.0	0.00	0.00
Other	0	0	0	0	0.0	0.0	0.00	0.00
		$0	0	0	0.0	0.0	$0.00	$0.00
Prescription Drugs								
Generic Scripts	63	$2,257	0	72	0.0	92.3	$31.34	$2.89
Single Source Brand	0	0	0	0	0.0	0.0	0.00	0.00
Multi-Source Brand	0	0	0	0	0.0	0.0	0.00	0.00
Other	1	4	0	1	0.0	1.3	4.24	0.01
		$2,261	0	73	0.0	93.6	$30.97	$2.90
Other Services								
Home Health	225	$47,512	0	753	0.0	965.4	$63.10	$60.91
Hospice	0	0	0	0	0.0	0.0	0.00	0.00
Durable Medical Equipment	28	4,607	0	10,102	0.0	12,951.3	0.46	5.91
Ambulance	102	75,108	0	6,743	0.0	8,644.9	11.14	96.29
Wheelchair Van	0	0	0	0	0.0	0.0	0.00	0.00
Optometry / Glasses	0	0	0	0	0.0	0.0	0.00	0.00
Private Duty Nursing	0	0	0	0	0.0	0.0	0.00	0.00
Personal Care	0	0	0	0	0.0	0.0	0.00	0.00
Adult Medical Day Care	0	0	0	0	0.0	0.0	0.00	0.00
Home and Community Based Care: DI	0	0	0	0	0.0	0.0	0.00	0.00
Home and Community Based Care: CI	0	0	0	0	0.0	0.0	0.00	0.00
Other	21	6,778	0	35	0.0	44.9	193.66	8.69
		$134,006	0	17,633	0.0	22,606.4	$7.60	$171.80
All Services		$7,940,856	832	41,578	1,066.7	53,305.1	$811.68	$10,180.59

Draft



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

Nicholas A. Toumpas
Commissioner

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9200 1-800-852-3345 Ext. 9200
Fax: 603-271-4912 TDD Access: 1-800-735-2964

April 9, 2014

The Honorable Mary Jane Wallner, Chairman
Fiscal Committee of the General Court

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Pursuant to the provisions of Chapter 3:7, II, Laws of 2014 and RSA 14:30-a, authorize the Department of Health and Human Services to transfer general funds in the amount of $484,424 and increase related Federal revenues in the amount of $118,057 and increase related Other revenues in the amount of $331,490 in the Department of Health and Human Services.

The transfers and adjustments are summarized below and detailed in the attached worksheets, effective upon approval of the Fiscal Committee and the Governor and Executive Council through June 30, 2014.

From: (Various Accounts):	Account		Amount
Office of Minority Health and Refugee Affairs	Various	$	(2,000)
Division of Homeless Housing Services	Various	$	-
Division of Family Assistance	Various	$	(25,146)
Division of Client Services	Various	$	(25,898)
Bureau of Elderly and Adult Services	Various	$	(232,050)
Glencliff Home for the Elderly	Various	$	(13,710)
Bureau of Behavioral Health	Various	$	(72,500)
Bureau of Developmental Services	Various	$	(113,120)
New Hampshire Hospital	Various	$	-
Office of the Commissioner	Various	$	-
Total Department of Health and Human Services			(484,424)

To: (Various Accounts):	Account		Amount
Office of Minority Health and Refugee Affairs	Various	$	-
Division of Homeless Housing Services	Various	$	-
Division of Family Assistance	Various	$	-
Division of Client Services	Various	$	136,675
Bureau of Elderly and Adult Services	Various	$	12,260

Glencliff Home for the Elderly	Various	$	10,000
Bureau of Behavioral Health	Various	$	5,600
Bureau of Developmental Services	Various	$	24,720
New Hampshire Hospital	Various	$	272,751
Office of the Commissioner	Various	$	22,418
Total Department of Health and Human Services		$	484,424

EXPLANATION

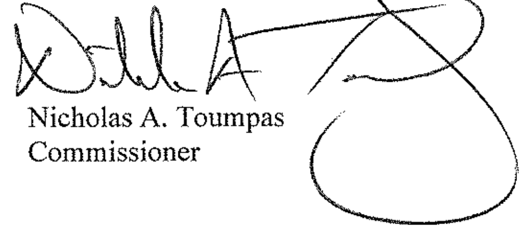
These transfers reflect adjustments to various salary class lines to address projected expenses in the Department. Expenditure patterns for the first nine months of SFY 2014 have been analyzed and taken into consideration when projecting expenditures for the balance of the year. Based upon this thorough review, a number of accounts were found to require additional funds, while other accounts were experiencing less than originally anticipated expenditures. This transfer will provide for the continued efficient operation of the Department.

The following is the information specifically required when transfers are requested, in accordance with the Budget Officer's instructional memorandum dated April 17, 1985, to support the above requested actions:

A. Justification: See the attached appendix for justification of the availability of funds and required additional funds.
B. Does this transfer involve continuing programs or one-time projects? This transfer involves continuing programs.
C. Is this transfer required to maintain existing program levels or will it increase the program level? This transfer is required to maintain existing program levels.
D. Cite any requirements which make this program mandatory. The programs of the Department are mandated by various state and federal laws.
E. Identify the source of funds on all accounts listed on this transfer. See the attached worksheet for the source of funds for all accounts.
F. Will there be any effect on revenue if this transfer is not approved? There is no anticipated effect on revenue as a result of this transfer. Federal participation in Department expenditures is detailed in the attached appendix.
G. Are funds expected to lapse if this transfer is not approved? It is anticipated that some funds will lapse whether this transfer is approved or not.
H. Are personnel services involved? No positions are being transferred as a result of this request.

The Department has conducted a detailed review of every line item in the budget to ensure that available funds are maximized to the greatest degree possible. An appendix is attached which summarizes the changes across the Department.

Respectfully submitted,



Nicholas A. Toumpas
Commissioner

Salaries	Account From	General Funds Only From	General Funds Only To	General Funds Only Net	Net FF/Oth	Account To
Office of Minority Health and Refugee Affairs	Various	$ (2,000)	$ -	(2,000)	14,000	Various
Division of Homeless Housing Services	Various	$ -	$ -	-	8,000	Various
Division of Family Assistance	Various	$ (25,146)	$ -	(25,146)	(24,854)	Various
Division of Client Services	Various	$ (25,898)	$ 136,675	110,777	96,279	Various
Bureau of Elderly and Adult Services	Various	$ (232,050)	$ 12,260	(219,790)	(159,610)	Various
Glencliff Home	Various	$ (13,710)	$ 10,000	(3,710)	-	Various
Bureau of Behavioral Health	Various	$ (72,500)	$ 5,600	(66,900)	(24,100)	Various
Bureau of Developmental Services	Various	$ (113,120)	$ 24,720	(88,400)	(57,600)	Various
New Hampshire Hospital	Various	$ -	$ 272,751	272,751	574,350	Various
Office of the Commissioner	Various	$ -	$ 22,418	22,418	23,082	Various
Total Department of Health and Human Services		(484,424)	484,424	-	449,547	
			Net Federal Funds		118,057	
			Net Other Funds		331,490	
					449,547	

	A	B	C	D	E	F	G	H	I	J	K	
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
4	LAWSON ACCOUNTING FORMAT											
5		COMPA	N/A	ACCOUNTING UNIT	CLASS	ACCOUNT						
6												
7	OFFICE OF MINORITY HEALTH AND REFUGEE AFFAIRS											
8												
9		Minority Hlth/Refugee Affairs										
10		010	042	79210000	000	403900	Federal Funds	(3,000)				
11		010	042	79210000			Other Funds	-				
12		010	042	79210000			General Funds	(2,000)	(2,000)			
13		Total Revenue						(5,000)				
14												
15		010	042	79210000	010	500100	Perm - Classified	(5,000)			$ (2,000)	
16		Total Expense						(5,000)				(2,000)
17												
18		Refugee Services										
19		010	042	79220000	000	408181	Federal Funds	17,000				
20		010	042	79220000			Other Funds	-				
21		010	042	79220000			General Funds	-				
22		Total Revenue						17,000				
23												
24		010	042	79220000	010	500100	Perm - Classified	4,000			$ -	
25		010	042	79220000	050	500109	Personnel - Temporary	13,000			$ -	
26		Total Expense						17,000				-
27												
28		TOTAL OFFICE OF MINORITY HEALTH AND REFUGEE AFFAIRS								(2,000)		(2,000)
29												
30	DIVISION OF HOMELESS HOUSING SERVICES											
31												
32		Housing - Shelter Program										
33		010	042	79270000	000	408072	Federal Funds	$ 8,000				
34		010	042	79270000			Other Funds	$ -				
35		010	042	79270000			General Funds	$ -	$ -			
36		Total Revenue						$ 8,000				
37												
38		010	042	79270000	050	500109	Part Time Salaries	$ 8,000			$ -	
39		Total Expense						$ 8,000				$ -
40												
41		TOTAL DIVISION OF HOMELESS HOUSING SERVICES								$ -		$ -
42												
43	DIVISION OF FAMILY ASSISTANCE											
44												
45		Directors Office										
46		010	045	61250000	000	403950	Federal Funds	$ (11,927)				

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
47		010	045	61250000	007	409282	Other Funds	$ -				
48		010	045	61250000			General Funds	$ (13,073)	$ (13,073)			
49		Total Revenue						$ (25,000)				
50												
51		010	045	61250000	010	500100	Personal Services - Permanent	$ (25,000)			$ (13,073)	
52		Total Expense						$ (25,000)				$ (13,073)
53												
54		**Employment Support**										
55		010	045	61270000	000	403719	Federal Funds	$ (12,927)				
56		010	045	61270000			Other Funds	$ -				
57		010	045	61270000			General Funds	$ (12,073)	$ (12,073)			
58		Total Revenue						$ (25,000)				
59												
60		010	045	61270000	010	500100	Personal Services - Permanent	$ (25,000)			$ (12,073)	
61		Total Expense						$ (25,000)				$ (12,073)
62												
63		**TOTAL DIVISION OF FAMILY ASSISTANCE**								**$ (25,146)**		**$ (25,146)**
64												
65	**DIVISION OF CLIENT SERVICES**											
66												
67		**Field Operations**										
68		010	045	79930000	000	403959	Federal Funds	$ 117,075				
69		010	045	79930000	007	409282	Other Funds	$ -				
70		010	045	79930000			General Funds	$ 132,925	$ 132,925			
71		Total Revenue						$ 250,000				
72												
73		010	045	79930000	018	500106	Overtime	$ 250,000			$ 132,925	
74		Total Expense						$ 250,000				$ 132,925
75												
76		**Client Eligibility & Enroll Ops (MCS)**										
77		010	045	79960000	000	403951	Federal Funds	$ (20,796)				
78		010	045	79960000			Other Funds	$ -				
79		010	045	79960000			General Funds	$ (22,148)	$ (22,148)			
80		Total Revenue						$ (42,944)				
81												
82		010	045	79960000	010	500100	Personal Services - Permanent	$ (50,444)			$ (25,898)	
83		010	045	79960000	018	500106	Overtime	$ 7,500			$ 3,750	
84		Total Expense						$ (42,944)				$ (22,148)
85												
86		**TOTAL DIVISION OF CLIENT SERVICES**								**$ 110,777**		**$ 110,777**
87												
88	**BUREAU OF ELDERLY & ADULT SERVICES**											
89												
90		**Office of Bureau Chief**										
91			048	78730000	000	404429	Federal Funds	$ 625				

	A	B	C	D	E	F	G	H	I	J	K	
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
92		010	048	78730000			Other Funds	$ -				
93		010	048	78730000			General Funds	$ 1,875	$ 1,875			
94		Total Revenue						$ 2,500				
95												
96		010	048	78730000	010	500100	Personal Services - Permanent	$ 700			$ 525	
97		010	048	78730000	012	500128	Personal Services - Unclassifie	$ 1,800			$ 1,350	
98		Total Expense						$ 2,500				$ 1,875
99												
100		**Long Term Care Ombudsman**										
101		010	048	89300000	000	404476	Federal Funds	$ (3,250)				
102		010	048	89300000			Other Funds	$ -				
103		010	048	89300000			General Funds	$ (9,750)	$ (9,750)			
104		Total Revenue						$ (13,000)				
105												
106		010	048	89300000	010	500100	Personal Services - Permanent	$ (13,000)			$ (9,750)	
107		Total Expense						$ (13,000)				$ (9,750)
108												
109		**Nursing Staff**										
110		010	048	89310000	000	404674	Federal Funds	$ (108,000)				
111		010	048	89310000			Other Funds	$ -				
112		010	048	89310000			General Funds	$ (36,000)	$ (36,000)			
113		Total Revenue						$ (144,000)				
114												
115		010	048	89310000	010	500100	Personal Services - Permanent	$ (175,000)			$ (43,750)	
116		010	048	89310000	018	500106	Overtime	$ 31,000			$ 7,750	
117		Total Expense						$ (144,000)				$ (36,000)
118												
119		**Field Operations**										
120		010	048	92500000	000	404825	Federal Funds	$ (25,785)				
121		010	048	92500000			Other Funds	$ -				
122		010	048	92500000			General Funds	$ (146,115)	$ (146,115)			
123		Total Revenue						$ (171,900)				
124												
125		010	048	92500000	010	500100	Personal Services - Permanent	$ (175,000)			$ (148,750)	
126		010	048	92500000	012	500128	Personal Services - Unclassifie	$ 2,800			$ 2,380	
127		010	048	92500000	018	500106	Overtime	$ 300			$ 255	
128		Total Expense						$ (171,900)				$ (146,115)
129												
130		**Adm on Aging**										
131		010	048	78720000	000	408177	Federal Funds	$ (13,200)				
132		010	048	78720000			Other Funds	$ -				
133		010	048	78720000			General Funds	$ (19,800)	$ (19,800)			
134		Total Revenue						$ (33,000)				
135												
136		010	048	78720000	010	500100	Personal Services - Permanent	$ (33,000)			$ (19,800)	

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
137		Total Expense						$ (33,000)				$ (19,800)
138												
139		**Medicaid Administration**										
140		010	048	78560000	000	404596	Federal Funds	$ (10,000)				
141		010	048	78560000			Other Funds	$ -				
142		010	048	78560000			General Funds	$ (10,000)	$ (10,000)			
143		Total Revenue						$ (20,000)				
144												
145		010	048	78560000	010	500100	Personal Services - Permanent	$ (20,000)			$ (10,000)	
146		Total Expense						$ (20,000)				$ (10,000)
147												
148												
149		**TOTAL BUREAU OF ELDERLY AND ADULT SERVICES**								**$ (219,790)**		**$ (219,790)**
150												
151	**GLENCLIFF HOME**											
152												
153		**Maintenance**										
154		010	091	78920000	000		Federal Funds	$ -				
155		010	091	78920000			Other Funds	$ -				
156		010	091	78920000			General Funds	$ (3,710)	$ (3,710)			
157		Total Revenue						$ (3,710)				
158												
159		010	091	78920000	010	500100	Personal Services-Perm	$ (11,710)			$ (11,710)	
160		010	091	78920000	018	500106	Overtime	$ 10,000			$ 10,000	
161		010	091	78920000	050	500109	Personal Services-Temp	$ (2,000)			$ (2,000)	
162		Total Expense						$ (3,710)				$ (3,710)
163												
164		**TOTAL FOR GLENCLIFF HOME**								**$ (3,710)**		**$ (3,710)**
165												
166	**BUREAU OF BEHAVIORAL HEALTH**											
167												
168		**CMH Program Support**										
169		010	092	59450000	000	408147	Federal Funds	$ (11,900)				
170		010	092	59450000			Other Funds	$ -				
171		010	092	59450000			General Funds	$ (23,100)	$ (23,100)			
172		Total Revenue						$ (35,000)				
173												
174		010	092	59450000	010	500100	Personal Services - Permanent	$ (35,000)			$ (23,100)	
175		Total Expense						$ (35,000)				$ (23,100)
176												
177		**Financial Management**										
178		010	092	70010000	000	404560	Federal Funds	$ (3,000)				
179		010	092	70010000			Other Funds	$ -				
180		010	092	70010000			General Funds	$ (7,000)	$ (7,000)			
181		T[illegible]evenue						$ [illegible]0,000)				

	A		C	D	E	F	G		I	J	K	
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
182												
183		010	092	70010000	010	500100	Personal Services - Permanent	$ (18,000)			$ (12,600)	
184		010	092	70010000	050	500109	Personal Service Temp	$ 8,000			$ 5,600	
185		Total Expense						$ (10,000)				$ (7,000)
186												
187		**Office of Director**										
188		010	092	78770000	000	406762	Federal Funds	$ (9,200)				
189		010	092	78770000			Other Funds	$ -				
190		010	092	78770000			General Funds	$ (36,800)	$ (36,800)			
191		Total Revenue						$ (46,000)				
192												
193		010	092	78770000	010	500100	Personal Services - Permanent	$ (46,000)			$ (36,800)	
194		Total Expense						$ (46,000)				$ (36,800)
195												
196		**TOTAL BUREAU OF BEHAVIORAL HEALTH**								**$ (66,900)**		**$ (66,900)**
197												
198	**BUREAU OF DEVELOPMENTAL SERVICES**											
199												
200		**Special Medical Services**										
201		010	093	51910000	000	404599	Federal Funds	$ (18,000)				
202		010	093	51910000			Other Funds	$ -				
203		010	093	51910000			General Funds	$ (42,000)	$ (42,000)			
204		Total Revenue						$ (60,000)				
205												
206		010	093	51910000	010	500100	Personal Services - Permanent	$ (60,000)			$ (42,000)	
207		Total Expense						$ (60,000)				$ (42,000)
208												
209		**Program Support**										
210		010	093	59470000	000	408148	Federal Funds	$ (21,600)				
211		010	093	59470000			Other Funds	$ -				
212		010	093	59470000			General Funds	$ (38,400)	$ (38,400)			
213		Total Revenue						$ (60,000)				
214												
215		010	093	59470000	010	500100	Personal Services - Permanent	$ (83,000)			$ (53,120)	
216		010	093	59470000	012	500128	Personal Services - Unclassifie	$ 5,000			$ 3,200	
217		010	093	59470000	018	500106	Overtime	$ 5,000			$ 3,200	
218		010	093	59470000	050	500109	Personal Service Temp	$ 13,000			$ 8,320	
219		Total Expense						$ (60,000)				$ (38,400)
220												
221		**NH Designated Receiving Facility**										
222		010	093	71640000	000		Federal Funds	$ -				
223		010	093	71640000			Other Funds	$ -				
224		010	093	71640000			General Funds	$ 10,000	$ 10,000			
225		Total Revenue						$ 10,000				
226												

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
227		010	093	71640000	018	500106	Overtime	$ 10,000			$ 10,000	
228		Total Expense						$ 10,000				$ 10,000
229												
230		**Medicaid Compliance**										
231		010	093	71670000	000	403795	Federal Funds	$ (18,000)				
232		010	093	71670000			Other Funds	$ -				
233		010	093	71670000			General Funds	$ (18,000)	$ (18,000)			
234		Total Revenue						$ (36,000)				
235												
236		010	093	71670000	010	500100	Personal Services - Permanent	$ (36,000)			$ (18,000)	
237		Total Expense						$ (36,000)				$ (18,000)
238												
239		**Infant - Toddler Program**										
240		010	093	78520000	000	404287	Federal Funds	$ (1,000)				
241		010	093	78520000			Other Funds	$ -				
242		010	093	78520000			General Funds	$ -	$ -			
243		Total Revenue						$ (1,000)				
244												
245		010	093	78520000	010	500100	Personal Services - Permanent	$ (1,000)			$ -	
246		Total Expense						$ (1,000)				$ -
247												
248		**Social Services Block Grant DD**										
249		010	093	78580000	000	404982	Federal Funds	$ 1,000				
250		010	093	78580000			Other Funds	$ -				
251		010	093	78580000			General Funds	$ -	$ -			
252		Total Revenue						$ 1,000				
253												
254		010	093	78580000	010	500100	Personal Services - Permanent	$ 1,000			$ -	
255		Total Expense						$ 1,000				$ -
256												
257		**TOTAL BUREAU OF DEVELOPMENTAL SERVICES**								**$ (88,400)**		**$ (88,400)**
258												
259	**NEW HAMPSHIRE HOSPITAL**											
260												
261		**Administration**										
262		010	094	84000000	000	404444	Medicaid DSH	$ 9,330				
263		010	094	84000000			Other Funds	$ -				
264		010	094	84000000			General Funds	$ 21,770	$ 21,770			
265		Total Revenue						$ 31,100				
266												
267		010	094	84000000	018	500106	Overtime	$ 30,000			$ 21,000	
268		010	094	84000000	019	500105	Holiday Pay	$ 1,100			$ 770	
269		Total Expense						$ 31,100				$ 21,770
270												
271		**N[illegible] Facility/Patient Support**										

	A	B	C	D	E	F	G		I	J	K	
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
272		010	094	84100000	000	404448	Medicaid DSH	$ 22,630				
273		010	094	84100000	007		Other Funds	$ -				
274		010	094	84100000			General Funds	$ 50,370	$ 50,370			
275		Total Revenue						$ 73,000				
276												
277		010	094	84100000	018	500106	Overtime	$ 65,000			$ 44,850	
278		010	094	84100000	019	500105	Holiday Pay	$ 8,000			$ 5,520	
279		Total Expense						$ 73,000				$ 50,370
280												
281		**Acute Psychiatric Services**										
282		010	094	87500000	000	404434	Medicaid DSH	$ 222,900				
283		010	094	87500000	009	405921	Other Funds	$ 319,490				
284		010	094	87500000			General Funds	$ 200,611	$ 200,611			
285		Total Revenue						$ 743,001				
286												
287		010	094	87500000	018	500106	Overtime	$ 410,000			$ 110,700	
288		010	094	87500000	019	500105	Holiday Pay	$ 81,000			$ 21,870	
289		010	094	87500000	050	500109	Personal Svcs Temp Appoint	$ 252,000			$ 68,041	
290		Total Expense						$ 743,000				$ 200,611
291												
292		**TOTAL OF NEW HAMPSHIRE HOSPITAL**								**$ 272,751**		**$ 272,751**
293												
294	**OFFICE OF COMMISSIONER**											
295												
296		**Office of Commissioner**										
297		010	095	50000000	000	403900	Federal Funds	10,826				
298		010	095	50000000			General Funds	18,674	18,674			
299		Total Revenue						29,500				
300												
301		010	095	50000000	010	500100	Perm - Classified	500			$ 317	
302		010	095	50000000	011	500126	Perm - Unclassified	1,000			$ 633	
303		010	095	50000000	012	500128	Perm - Unclassified	28,000			$ 17,724	
304		Total Expense						29,500				18,674
305												
306		**Employee Assistance Program**										
307		010	095	50250000	000	403900	Federal Funds	256				
308		010	095	50250000			General Funds	3,744	3,744			
309		Total Revenue						4,000				
310												
311		010	095	50250000	010	500100	Perm - Classified	4,000			$ 3,744	
312		Total Expense						4,000				3,744
313												
314		**Homeland Security**										
315		010	095	71780000			Federal Funds	-				
316		010	095	71780000	009	407079	Federal Funds	12,000				

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
317		010	095	71780000			General Funds	-	-			
318		Total Revenue						12,000				
319												
320		010	095	71780000	018	500106	Overtime	12,000			$ -	
321		Total Expense						12,000				-
322												
323		TOTAL OFFICE OF THE COMMISSIONER								$ 22,418		$ 22,418
324												
325								**Total DHHS**		$ -		$ -

DEPARTMENT OF HEALTH AND HUMAN SERVICES
TRANSFER OF FUNDS SFY 2014 – Salaries (010, 011, 012, 018, 019, 050 & 059)

OFFICE OF MINORITY HEALTH AND REFUGEE SERVICES

05-95-042-422010-79210000
Office of Minority Health and Refugee Affairs

Funding in this organization represents costs associated with the operation of the Office of Minority Health and Refugee Affairs, which administers the programs, and policies that reduce health disparities in minority and refugee communities throughout the State. Funds are available in permanent personnel services (class 010) due to adjusted authorized exceeding the amount needed for currently filled positions. Source of funds for this transfer reflect the anticipated federal revenues from cost allocation earnings.

05-95-042-422010-79220000
Refugee Services

Funding in this organization represents costs associated with Refugee grants as awarded from the Office of Refugee Resettlement. Funds are needed in permanent personnel services (class 010) and personnel – temp (class 050) due to actual amount needed exceeding the amount budgeted for SFY 2014. Source of Funds: 100% Federal (Refugee Resettlement Grants).

DIVISION OF HOMELESS HOUSING SERVICES

05-95-042-423010-79270000
Housing Shelter Program

This accounting unit is the operating account for the US Department of Housing and Urban Development grants to the Bureau of Homeless and Housing Services (BHHS). Funds are required for the establishment of a new Part Time Salaries account (class 050) to fund a part time temporary position which will allow other Bureau staff to conduct required compliance site visits, training, and to provide technical assistance to emergency shelters. Earlier staff reductions reduced the Bureau's ability to perform these functions. Funds are available in Contracts for Program Services (class 102). Source of Funds is 100% Federal from US Department of Housing and Urban Development grants.

DIVISION OF FAMILY ASSISTANCE

05-95-045-450010-61250000
Director's Office

Funding in this organization represents costs associated with the administration of the Division and its programs. This transfer decreases Class 010, Salaries. This transfer will take projected surplus to help fund projected deficits in the Division. Source of Funds: 48% Federal Funds, 52% General Funds.

05-95-045-450010-61270000
Employment Support

Funding in this organization represents costs associated with the administration of the New Hampshire Employment Program (NHEP). This transfer decreases Class 010, Salaries. This transfer will take projected surplus to help fund projected deficits in the Division. Source of Funds: 52% Federal Funds, 48% General Funds.

DIVISION OF CLIENT SERVICES

05-95-045-451010-79930000
DFA Field Svcs

Funding in this organization represents costs associated with the staff in the district offices providing direct services to the clients of New Hampshire. This transfer increases Class 018, Overtime. The transfer for Class 018 is needed due to an increased demand of staff and due to the wage increases in 2014, additionally the transfer is needed due to the implementation of the NH Health Protection Program. This transfer will satisfy the projected shortfalls. Source of Funds: 47% Federal Funds, 53% General Funds

05-95-045-451010-79960000
Client Elig & Enrollment Operations

Funding in this appropriation primarily represents costs associated with the management and operation of Medicaid programs serving citizens throughout New Hampshire. This transfer decreases Class 010, Salaries. This transfer increases Class 018, Overtime. The transfer for Class 010 will take projected surplus to help fund projected deficits in the Division. The transfer for Class 018 is needed due to an increased demand of staff and due to the wage increases in 2014. Source of Funds: Class 010 - 49% Federal, 51% General, Class 018 – 50% Federal, 50% General

BUREAU OF ELDERLY AND ADULT SERVICES

05-95-048-480010-78730000
Office of Bureau Chief

Funding in this organization represents costs associated with overseeing all aspects of the Bureau of Elderly and Adult Services. Funds are needed in Class 010 (Personal Services – Permanent) and Class 012 (Personal Services – Unclassified) to cover an anticipated shortfall. Source of Funds: 75% General and 25% Federal.

05-95-048-480510-89300000
Long Term Care Ombudsman

Funding in this organization represents costs associated with providing long term care ombudsman services and to administrating grants received from the Administration for Community Living. Funds are available in Class 010 (Personal Services – Permanent) due to vacancies. Source of Funds: 75% General, 25% Federal.

05-95-048-480510-89310000
Nursing Staff

Funding in this organization represents costs associated with the determination of eligibility for BEAS services. Funds are needed in Class 018 (Overtime) due to the unanticipated expenses caused by extended vacancies. Funds are available in Class 010 (Personal Services – Permanent) due to vacancies. Source of Funds: 25% General and 75% Federal.

05-95-048-480510-92500000
Field Operations

Funding in this organization represents costs associated with direct social services to elderly and incapacitated adults. Funds are needed in Class 012 (Personal Services – Unclassified) and Class 018 (Overtime) to cover an anticipated shortfall. Funds are available in Class 010 (Personal Services – Permanent) due to vacancies. Source of Funds: 85% General and 15% Federal.

05-95-048-481010-78720000
Administration on Aging

Funding in this organization represents costs associated with administering grants received from the Administration for Community Living. Funds are available in Class 010 (Personal Services – Permanent) due to vacancies. Source of Funds: 60% General and 40% Federal.

05-95-048-481510-78560000
Medicaid Administration

Funding in this organization represents costs associated with administration of all Medicaid Services. Funds are available in Class 010 (Personal Services – Permanent) due to vacancies. Source of Funds: 50% General and 50% Federal.

GLENCLIFF HOME

05-95-091-910010-78920000
Maintenance

Funding in this organization represents costs associated with the Maintenance Department. Funds are available in Class 010 (Personal Services-Permanent) and Class 050 (Personnel – temp) due to savings from vacancies. Funds are needed in Class 018 (Overtime) due to temporary vacancies of 24-hour coverage positions.
Source of Funds: 100% General

BUREAU OF BEHAVIORAL HEALTH

05-95-092-920010-59450000
CMH Program Support

Funding in this accounting unit represents operational costs associated the Office of Community Mental Health Services. Funds are available in Class 010 (Personal Services - Permanent) due to vacancies. Source of Funds: 66% General, 34% Federal.

05-95-092-920010-70010000
Financial Management

Funding in this accounting unit represents costs associated with the Financial Management Unit. Funds are available in Class 010 (Personal Services - Permanent) due to a vacancy. Funds are needed in Class 050 (Personnel – Temp) due to budget shortage. Source of Funds: 70% General and 30% Federal.

05-95-092-920010-78770000
Office of Director

Funding in this accounting unit represents costs associated with the BBH Director's Office. Funds are available in Class 010 (Personal Services - Permanent) due to a vacancy. Source of Funds: 80% General and 20% Federal.

BUREAU OF DEVELOPMENTAL SERVICES

05-95-093-930010-51910000
Special Medical Services

Funding in this organization represents costs associated with the Special Medical Services unit within the Bureau of Developmental Services. Funds are available in Class 010 (Personal Services - Permanent) due to vacancies. Source of Funds: 70% General, 30% Federal.

05-95-093-930010-59470000
Program Support

Funding in this organization represents costs associated with the operation of the Community Developmental Services central office within the Bureau of Developmental Services. Funds are available in Class 010 (Personal Services - Permanent) due to vacancies. Funds are needed in Class 012 (Personal Services – Unclassified) to cover the retirement payout of a long-term employee. Funds are also needed in Class 018 (Overtime) and Class 050 (Personal Services Temp) to cover anticipated shortfalls caused by the implementation of the new MMIS system. Source of Funds: 64% General, 36% Federal.

05-95-093-930010-71640000

NH Designated Receiving Facility

Funding in this accounting unit represents costs associated with the operation of the Designated Receiving Facility in Laconia. Funds are needed in Class 018 (Overtime) to cover anticipated deficits caused by numerous vacancies. Source of Funds: 100% General.

05-95-093-930010-71670000
Medicaid Compliance

Funding in this organization represents costs associated with the unit that issuance of prior authorizations to Medicaid Providers for Medicaid Waiver services. Funds are available in Class 010 (Personal Services - Permanent) due to vacancies. Source of Funds: 50% General, 50% Federal.

05-95-093-930010-78520000
Toddler Program

Funding in this organization represents costs associated with the Part C Infant and Toddler Grant. Funds are available in Class 010 (Personal Services - Permanent) due to vacancies. Source of Funds: 100% Federal.

05-95-093-930010-78580000
Social Services Block Grant DD

Funding in this organization represents costs associated with the Partners In Health Program funded by the Social Services Block Grant. Funds are needed in Class 010 (Personal Services - Permanent) to cover an anticipated deficit. Source of Funds: 100% Federal.

NEW HAMPSHIRE HOSPITAL

05-95-094-940010-84000000
Administration

Funding in this organization represents costs associated with the administration of New Hampshire Hospital. Funds are necessary in class 018 (Overtime) and class 019 (Holiday Pay) to cover projected deficits caused by vacancies. Source of Funds: 30% Federal, 70% General.

05-95-094-940010-84100000
NHH-Facility/Patient Support

Funding in this organization represents costs associated with the operation of New Hampshire Hospital, Facility/Patient Support Services. Staff in these areas provides direct services to patients in Food and Nutritional Services, Environmental Services, Laundry Services and Maintenance. Funds are necessary in class 018 (Overtime) and class 019 (Holiday Pay) to cover projected deficits caused by vacancies. Source of Funds: 31% Federal, and 69% General.

05-95-094-940010-87500000
Acute Psychiatric Services

Funding in this organization represents costs associated with the operation of New Hampshire Hospital, Acute Psychiatric Services. These costs cover the direct expenses of supporting patients. Funds are necessary in class 018 (Overtime), class 019 (Holiday Pay) and class 050 to cover projected deficits caused by vacancies. Source of Funds: 30% Federal, 43% Other and 27% General.

OFFICE OF THE COMMISSIONER

05-95-095-950010-50000000
Office of the Commissioner

Funding in this organization represents costs associated with the operation of the Commissioner's Office. Funds are needed in permanent classified personnel services (class 010), Permanent Unclassified (class 011) and Permanent Unclassified (class 012) because actual costs exceed the adjusted authorized for currently filled positions. Source of funds for this transfer reflect the anticipated federal revenues from cost allocation earnings.

05-95-095-950010-50250000
Employee Assistance Program

Funding in this organization represents costs associated with the operation of this program that provides assistance to employees who are having problems in their work or personal lives by helping them secure appropriate assistance. Funds are needed in permanent classified personnel services (class 010) because actual costs exceed the adjusted authorized for currently filled positions. Source of funds for this transfer reflect the anticipated federal revenues from cost allocation earnings.

05-95-095-950010-71780000
Homeland Security

Funding in this organization represents costs associated with maintaining an emergency preparedness capability as required by the Radiological Emergency Response Plan (RERP) and NH RSA 107-B, Nuclear Planning and Response Program. Funds are required in Overtime (class 018) to align the state budget with the awarded budget from Department of Safety. Source of Funds: 100% Other (Dept of Safety).

FIS 14 068

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9200 1-800-852-3345 Ext. 9200
Fax: 603-271-4912 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Commissioner

April 9, 2014

The Honorable Mary Jane Wallner, Chairman
Fiscal Committee of the General Court

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Pursuant to the provisions of Chapter 3:7, II, Laws of 2014 and RSA 14:30-a, authorize the Department of Health and Human Services to transfer general funds in the amount of $4,456,546 and increase related Federal revenues in the amount of $17,596,555 and decrease related Other revenues in the amount of ($785,531) in the Department of Health and Human Services.

The transfers and adjustments are summarized below and detailed in the attached worksheets, effective upon approval of the Fiscal Committee and the Governor and Executive Council through June 30, 2014.

From: (Various Accounts):	Account		Amount
Division for Children, Youth and Families	Various	$	-
Office of Minority Health and Refugee Affairs	Various	$	(640)
Division of Homeless Housing Services	Various	$	(1,000)
Division of Family Assistance	Various	$	(1,844,690)
Division of Client Services	Various	$	(4,500)
Office of Medicaid Business and Policy	Various	$	(58,750)
Bureau of Elderly and Adult Services	Various	$	(958,880)
Division of Community Based Services	Various	$	(212,000)
Division of Public Health Services	Various	$	(35,304)
Glencliff Home for the Elderly	Various	$	(131,287)
Bureau of Behavioral Health	Various	$	(1,292)
Bureau of Developmental Services	Various	$	(5,378)
New Hampshire Hospital	Various	$	(762,965)
Office of the Commissioner	Various	$	(152,880)
Office of Administration	Various	$	(286,980)
Office of Information Services	Various	$	-
Total Department of Health and Human Services		$	(4,456,546)

To: (Various Accounts):	Account		Amount
Division for Children, Youth and Families	Various	$	-
Office of Minority Health and Refugee Affairs	Various	$	640
Division of Homeless Housing Services	Various	$	1,000
Division of Family Assistance	Various	$	443,742
Division of Client Services	Various	$	43,368
Office of Medicaid Business and Policy	Various	$	77,022
Bureau of Elderly and Adult Services	Various	$	286,700
Division of Public Health Services	Various	$	-
Glencliff Home for the Elderly	Various	$	120,000
Bureau of Behavioral Health	Various	$	1,292
Bureau of Developmental Services	Various	$	5,378
New Hampshire Hospital	Various	$	247,710
Office of the Commissioner	Various	$	47,061
Office of Administration	Various	$	202,320
Office of Information Services	Various	$	2,980,313
Total Department of Health and Human Services		$	4,456,546

EXPLANATION

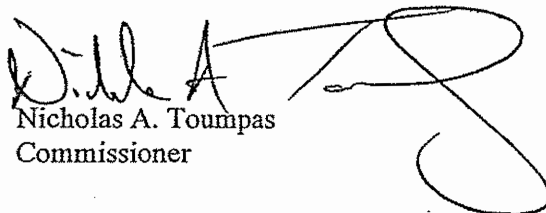
These transfers reflect adjustments to various other class lines to address projected expenses in the Department. Expenditure patterns for the first nine months of SFY 2014 have been analyzed and taken into consideration when projecting expenditures for the balance of the year. Based upon this thorough review, a number of accounts were found to require additional funds, while other accounts were experiencing less than originally anticipated expenditures. This transfer will provide for the continued efficient operation of the Department.

The following is the information specifically required when transfers are requested, in accordance with the Budget Officer's instructional memorandum dated April 17, 1985, to support the above requested actions:

A. Justification: See the attached appendix for justification of the availability of funds and required additional funds.
B. Does this transfer involve continuing programs or one-time projects? This transfer involves continuing programs.
C. Is this transfer required to maintain existing program levels or will it increase the program level? This transfer is required to maintain existing program levels.
D. Cite any requirements which make this program mandatory. The programs of the Department are mandated by various state and federal laws.
E. Identify the source of funds on all accounts listed on this transfer. See the attached worksheet for the source of funds for all accounts.
F. Will there be any effect on revenue if this transfer is not approved? There is no anticipated effect on revenue as a result of this transfer. Federal participation in Department expenditures is detailed in the attached appendix.

G. Are funds expected to lapse if this transfer is not approved? It is anticipated that some funds will lapse whether this transfer is approved or not.
H. Are personnel services involved? No positions are being transferred as a result of this request.

Respectfully submitted,



Nicholas A. Toumpas
Commissioner

Other	Account From	General Funds Only From	General Funds Only To	General Funds Only Net	Net FF/Oth	Account To
Division for Children, Youth and Families	Various	-	-	-	-	Various
Office of Minority Health and Refugee Affairs	Various	(640)	640	-	2,062	Various
Division of Homeless Housing Services	Various	(1,000)	1,000	-	(8,000)	Various
Division of Child Support Services	Various	-	-	-	-	Various
Division of Family Assistance	Various	(1,844,690)	443,742	(1,400,948)	1,480,286	Various
Division of Client Services	Various	(4,500)	43,368	38,868	40,583	Various
Office of Medicaid Business and Policy	Various	(58,750)	77,022	18,272	565,588	Various
Bureau of Elderly and Adult Services	Various	(958,880)	286,700	(672,180)	702,780	Various
Division of Community Based Services	Various	(212,000)	-	(212,000)	(53,000)	Various
Division of Public Health Services	Various	(35,304)	-	(35,304)	-	Various
Glencliff Home	Various	(131,287)	120,000	(11,287)	-	Various
Bureau of Behavioral Health	Various	(1,292)	1,292	-	740	Various
Bureau of Developmental Services	Various	(5,378)	5,378	-	3,503,500	Various
New Hampshire Hospital	Various	(762,965)	247,710	(515,255)	(1,434,851)	Various
Office of the Commissioner	Various	(152,880)	47,061	(105,819)	(134,181)	Various
Office of Administration	Various	(286,980)	202,320	(84,660)	(49,840)	Various
Office of Information Services	Various	-	2,980,313	2,980,313	12,195,357	Various
Total Department of Health and Human Services		(4,456,546)	4,456,546	-	16,811,024	
			Net Federal Funds		17,596,555	
			Net Other Funds		(785,531)	
					16,811,024	
					-	

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
4	LAWSON ACCOUNTING FORMAT											
5		COMP/	N/A	ACCOUNTING UNIT	CLASS	ACCOUNT						
6												
7	DIVISION FOR CHILDREN, YOUTH AND FAMILIES											
8												
9		OJJDP										
10		010	042	79060000	000	404865	Federal Funds	(21,380)				
11		010	042	79060000			Other Funds	-				
12		010	042	79060000			General Funds	-	$ -			
13		Total Revenue						(21,380)				
14												
15												
16		010	042	79060000	020	500200	Current Expenses				$ -	
17		010	042	79060000	026	500251	Organizational Dues				$ -	
18		010	042	79060000	072	502624	Grants Federal	(21,380)			$ -	
19		Total Expense						(21,380)				$ -
20												
21		OJJDP TITLE V GRANT										
22		010	042	79080000	000	404865	Federal Funds	21,380				
23		010	042	79080000			Other Funds	-				
24		010	042	79080000			General Funds	-	$ -			
25		Total Revenue						21,380				
26												
27		010	042	79080000	072	500574	Contracts For Program Servic	21,380			$ -	
28		Total Expense						21,380				$ -
29												
30		TOTAL DIVISION FOR CHILDREN, YOUTH AND FAMILIES								$ -		$ -
31												
32	OFFICE OF MINORITY HEALTH AND REFUGEE AFFAIRS											
33												
34		Minority Hlth/Refugee Affairs										
35		010	042	79210000	000	403900	Federal Funds	62				
36		010	042	79210000			Other Funds	-				
37		010	042	79210000			General Funds	-	-			
38		Total Revenue						62				
39												
40		010	042	79210000	039	500188	Telecommunications	1,600			$ 640	
41		010	042	79210000	041	500801	Audit Fees	62			$ -	
42		010	042	79210000	070	500704	In-State Travel	(1,600)			$ (640)	

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
43		Total Expense						62				-
44												
45		**Refugee Services**										
46		010	042	79220000	000	408181	Federal Funds	1,000				
47		010	042	79220000			Other Funds	-				
48		010	042	79220000			General Funds	-				
49		Total Revenue						1,000				
50												
51		010	042	79220000	039	500188	Telecommunications	1,000			-	
52		Total Expense						1,000				-
53												
54		**OMH State Partnership Grant**										
55		010	042	79230000	000	400874	Federal Funds	-				
56		010	042	79230000			Other Funds	-				
57		010	042	79230000			General Funds	-	-			
58		Total Revenue						-				
59												
60		010	042	79230000	039	500188	Telecommunications	325			$ -	
61		010	042	79230000	066	500556	Employee Training	(325)			$ -	
62		Total Expense						-				-
63												
64		**Health Professional Opportunity Grant**										
65		010	042	79240000	000	406923	Federal Funds	1,000				
66		010	042	79240000	000		Other Funds	-				
67		010	042	79240000	000		General Funds	-				
68		Total Revenue						1,000				
69												
70		010	042	79240000	041	500801	Audit Fees	1,000			-	
71		Total Expense						1,000				-
72												
73		**TOTAL OFFICE OF MINORITY HEALTH AND REFUGEE AFFAIRS**								0		-
74												
75	**DIVISION OF HOMELESS HOUSING SERVICES**											
76												
77		**Housing - Shelter Program**										
78		010	042	79270000	000	408072	Federal Funds	$ (8,000)				
79		010	042	79270000			Other Funds	$ -				
80		010	042	79270000			General Funds	$ -	$ -			
81		Total Revenue						$ (8,000)				
82												
83		010	[illegible]	79270000	102	500731	Contracts for Prog Serv	$ (8,000)			$	

	A	B		D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
84		Total Expense						$ (8,000)				$ -
85												
86		**Emergency Shelters**										
87		010	042	79280000	000		Federal Funds	$ -				
88		010	042	79280000			Other Funds	$ -				
89		010	042	79280000			General Funds	$ -	$ -			
90		Total Revenue						$ -				
91												
92		010	042	79280000	039	500188	Telecommunications	$ 1,000			$ 1,000	
93		010	042	79280000	102	500731	Contracts for Prog Serv	$ (1,000)			$ (1,000)	
94		Total Expense						$ -				$ -
95												
96		**TOTAL DIVISION OF HOMELESS HOUSING SERVICES**								$ -		$ -
97												
98	**DIVISION OF CHILD SUPPORT SERVICES**											
99												
100		**Child Support Services**										
101		010	042	79290000	000	403955	Federal Funds	$ -				
102		010	042	79290000	009	407126	Other Funds	$ -				
103		010	042	79290000			General Funds	$ -	$ -			
104		Total Revenue						$ -				
105												
106		010	042	79290000	041	500801	Audit Funds Set Aside	$ 8,000			$ -	
107		010	042	79290000	042	500620	Additional Fringe Benefit	$ (8,000)			$ -	
108		Total Expense						$ -				$ -
109												
110		**TOTAL DIVISION OF CHILD SUPPORT SERVICES**								$ -		$ -
111												
112	**DIVISION OF FAMILY ASSISTANCE**											
113												
114		**Directors Office**										
115		010	045	61250000	000	403950	Federal Funds	$ 641,448				
116		010	045	61250000	007	409282	Other Funds	$ -				
117		010	045	61250000			General Funds	$ (659,448)	$ (659,448)		$ -	
118		Total Revenue						$ (18,000)				
119												
120		010	045	61250000	010	500100	Perm - Clasified	$ (181,000)			$ (181,000)	
121		010	045	61250000	010	500100	Perm - Clasified	$ 181,000			$ -	
122		010	045	61250000	103	502664	Contracts for Op. Services	$ (469,000)			$ (469,000)	
123		010	045	61250000	103	502664	Contracts for Op. Services	$ 469,000			$ -	
124		010	045	61250000	039	500188	Telecommunications	$ (18,000)			$ (9,448)	

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
125		Total Expense						$ (18,000)				$ (659,448)
126												
127		**Employment Support**										
128		010	045	61270000	000	403719	Federal Funds	$ 838,838				
129		010	045	61270000			General Funds	$ (1,181,500)	$ (1,181,500)			
130		Total Revenue						$ (342,662)				
131												
132		010	045	61270000	020	500200	Current Expenses	$ (10,000)			$ (4,563)	
133		010	045	61270000	039	500188	Telecommunications	$ (11,000)			$ (5,357)	
134		010	045	61270000	041	500801	Audit Fees	$ 838			$ -	
135		010	045	61270000	102	500734	Contracts for Program Services	$ 985,405			$ -	
136		010	045	61270000	102	500734	Contracts for Program Services	$ (985,405)			$ (985,405)	
137		010	045	61270000	102	500734	Contracts for Program Services	$ (332,500)			$ (189,917)	
138		010	045	61270000	502	500891	Payments to Providers	$ 10,000			$ 3,742	
139		Total Expense						$ (342,662)				$ (1,181,500)
140												
141		**Separate State TANF**										
142		010	045	61530000			General Funds	$ 15,000	$ 15,000			
143		Total Revenue						$ 15,000				
144												
145		010	045	61530000	501	500425	Payments to Clients	$ 15,000			$ 15,000	
146		Total Expense						$ 15,000				$ 15,000
147												
148		**OAA APTD Grants**										
149		010	045	61700000			General Funds	$ 50,000	$ 50,000			
150		Total Revenue						$ 50,000				
151												
152		010	045	61700000	501	500425	Payments to Clients	$ 50,000			$ 50,000	
153		Total Expense						$ 50,000				$ 50,000
154												
155		**APTD Grants**										
156		010	045	61740000			General Funds	$ 375,000	$ 375,000			
157		Total Revenue						$ 375,000				
158												
159		010	045	61740000	501	500425	Payments to Clients	$ 375,000			$ 375,000	
160		Total Expense						$ 375,000				$ 375,000
161												
162		**TOTAL DIVISION OF FAMILY ASSISTANCE**								**$ (1,400,948)**		**$ (1,400,948)**
163												
164	**DIVISION OF CLIENT SERVICES**											
165												

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
166		**Field Operations**										
167		010	045	79930000	000	403959	Federal Funds	$ 44,283				
168		010	045	79930000	007	409282	Other Funds	$ -				
169		010	045	79930000			General Funds	$ 42,168	$ 42,168			
170		Total Revenue						$ 86,451				
171												
172		010	045	79930000	020	500200	Current Expenses	$ 50,000			$ 26,030	
173		010	045	79930000	041	500801	Audit Fees	$ 5,451			$ -	
174		010	045	79930000	039	500188	Telecommunications	$ 31,000			$ 16,138	
175		Total Expense						$ 86,451				$ 42,168
176												
177		**DCYF FIL OPS PG ELB**										
178		010	045	79940000	000	404671	Federal Funds	$ 800				
179		010	045	79940000			Other Funds	$ -				
180		010	045	79940000			General Funds	$ 1,200	$ 1,200			
181		Total Revenue						$ 2,000				
182												
183		010	045	79940000	039	500188	Telecommunications	$ 2,000			$ 1,200	
184		Total Expense						$ 2,000				$ 1,200
185												
186		**Client Eligibility & Enroll Ops (MCS)**										
187		010	045	79960000	000	403951	Federal Funds	$ (2,000)				
188		010	045	79960000			Other Funds	$ -				
189		010	045	79960000			General Funds	$ (2,000)	$ (2,000)			
190		Total Revenue						$ (4,000)				
191												
192		010	045	79960000	039	500188	Telecommunications	$ (4,000)			$ (2,000)	
193		Total Expense						$ (4,000)				$ (2,000)
194												
195		**Disability Determination Unit**										
196		010	045	79970000	000		Federal Funds	$ (2,500)				
197		010	045	79970000			Other Funds	$ -				
198		010	045	79970000			General Funds	$ (2,500)	$ (2,500)			
199		Total Revenue						$ (5,000)				
200												
201		010	045	79970000	020	500200	Current Expenses	$ (5,000)			$ (2,500)	
202		Total Expense						$ (5,000)				$ (2,500)
203												
204		**TOTAL DIVISION OF CLIENT SERVICES**								**$ 38,868**		**$ 38,868**
205												
206	**OFFICE OF MEDICAID BUSINESS AND POLICY**											

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
207												
208		**Medicaid Administration**										
209		010	047	79370000	000	403951	Federal Funds	$1,250				
210		010	047	79370000			Other Funds	$ -				
211		010	047	79370000			General Funds	$0	$ -			
212		Total Revenue						$ 1,250				
213												
214		010	047	79370000	041	500801	Audit Set Aside	$ 1,250			$0	
215		Total Expense						$ 1,250				$0
216												
217		**Provider Payments**										
218		010	047	79400000	000	403978	Federal Funds	($45,000)				
219		010	047	79400000			Other Funds	$ -				
220		010	047	79400000			General Funds	($50,000)	$ (50,000)			
221		Total Revenue						$ (95,000)				
222												
223		010	047	79400000	041	500801	Audit Set Aside	$ 5,000			$0	
224		010	047	79400000	100	500726	Prescription Drug Expense	$ (100,000)			($50,000)	
225		Total Expense						$ (95,000)				($50,000)
226												
227		**BCC Program**										
228		010	047	79410000	000	403978	Federal Funds	$ 50				
229		010	047	79410000			Other Funds	$ -				
230		010	047	79410000			General Funds	$ -	$ -			
231		Total Revenue						$ 50				
232												
233		010	047	79410000	041	500801	Audit Set Aside	$ 50			$0	
234		010	047	79410000	101	500729	Provider Payments	$ 25,000			$8,750	
235		010	047	79410000	565	500917	Outpatient Hospital	$ (25,000)			($8,750)	
236		Total Expense						$ 50				$0
237												
238		**Family Planning**										
239		010	047	79420000	000	403978	Federal Funds	$ 90,090				
240		010	047	79420000			Other Funds	$ -				
241		010	047	79420000			General Funds	$ 10,000	$ 10,000			
242		Total Revenue						$ 100,090				
243												
244		010	047	79420000	041	500801	Audit Set Aside	$ 90			$0	
245		010	047	79420000	101	500729	Provider Payments	$ 100,000			$10,000	
246		Total Expense						$ 100,090				$10,000
247												

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
248		**Medicaid Care Management**										
249		010	047	79480000	000	403978	Federal Funds	$ 519,198				
250		010	047	79480000			Other Funds	$ -				
251		010	047	79480000			General Funds	$ 58,272	$ 58,272			
252		Total Revenue						$ 577,470				
253												
254		010	047	79480000	041	500801	Audit Set Aside	$ (5,250)			$ -	
255		010	047	79480000	102	500731	Contracts for Program Services	$ 582,720			$ 58,272	
256		Total Expense						$577,470				$ 58,272
257												
258		**TOTAL OFFICE OF MEDICAID BUSINESS AND POLICY**								**$18,272**		**$ 18,272**
259												
260	**BUREAU OF ELDERLY AND ADULT SERVICES**											
261												
262		**Admin on Aging Svcs Grant - SMPP**										
263		010	048	33170000	000	404950	Federal Funds	$ 500				
264		010	048	33170000			Other Funds	$ -				
265		010	048	33170000			General Funds	$ -	$ -			
266		Total Revenue						$ 500				
267												
268												
269		010	048	33170000	041	500801	Audit Set Aside	$ 500			$ -	
270		Total Expense						$ 500				$ -
271												
272		**Nursing Services - County Participation**										
273		010	048	59420000	000	404362	Federal Funds	$ 38,100				
274		010	048	59420000			Other Funds	$ -				
275		010	048	59420000			General Funds	$ (23,100)	$ (23,100)			
276		Total Revenue						$ 15,000				
277												
278												
279		010	048	59420000	041	500801	Audit Set Aside	$ 15,000			$ -	
280		010	048	59420000	506	500895	Home Support Waiver Services	$ 2,750,000			$ 189,200	
281		010	048	59420000	529	500370	Home Health Care Waiver Serv	$ (2,750,000)			$ (212,300)	
282		Total Expense						$ 15,000				$ (23,100)
283												
284		**Proshare**										
285		010	048	59430000	000	404362	Federal Funds	$ 17,500				
286		010	048	59430000			Other Funds	$ -				
287		010	048	59430000			General Funds	$ -	$ -			
288		Total Revenue						$ 17,500				

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
289												
290												
291		010	048	59430000	041	500801	Audit Set Aside	$ 17,500			$ -	
292		Total Expense						$ 17,500				$ -
293												
294		**Medicaid Quality Incentive Pmt**										
295		010	048	59440000	000	404362	Federal Funds	$ 7,000				
296		010	048	59440000			Other Funds	$ -				
297		010	048	59440000			General Funds	$ -	$ -			
298		Total Revenue						$ 7,000				
299												
300		010	048	59440000	041	500801	Audit Set Aside	$ 7,000			$ -	
301		Total Expense						$ 7,000				$ -
302												
303		**Nursing Services**										
304		010	048	61730000	000	404362	Federal Funds	$ 75,000				
305		010	048	61730000			Other Funds	$ -				
306		010	048	61730000			General Funds	$ 75,000	$ 75,000			
307		Total Revenue						$ 150,000				
308												
309		010	048	61730000	565	500917	Outpatient Hospital	$ 150,000			$ 75,000	
310		Total Expense						$ 150,000				$ 75,000
311												
312		**LTC Assessment & Counseling**										
313		010	048	61800000	000	404362	Federal Funds	$ 1,800				
314		010	048	61800000			Other Funds	$ -				
315		010	048	61800000			General Funds	$ 1,250	$ 1,250			
316		Total Revenue						$ 3,050				
317												
318		010	048	61800000	039	500190	Telecommunications	$ 2,500			$ 1,250	
319		010	048	61800000	041	500801	Audit Set Aside	$ 550			$ -	
320		Total Expense						$ 3,050				$ 1,250
321												
322		**Medicaid Administration**										
323		010	048	78560000	000	404596	Federal Funds	$ 750				
324		010	048	78560000			Other Funds	$ -				
325		010	048	78560000			General Funds	$ 750	$ 750			
326		Total Revenue						$ 1,500				
327												
328		010	048	78560000	039	500190	Telecommunications	$ 1,500			$ 750	
329		Total Exp						$ 1,500				750

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
330												
331		**Administration on Aging**										
332		010	048	78720000	000	404871	Federal Funds	$ -				
333		010	048	78720000			Other Funds	$ -				
334		010	048	78720000			General Funds	$ 5,500	$ 5,500			
335		Total Revenue						$ 5,500				
336												
337		010	048	78720000	020	500200	Current Expense	$ 3,000			$ 3,000	
338		010	048	78720000	039	500190	Telecommunications	$ 2,500			$ 2,500	
339		Total Expense						$ 5,500				$ 5,500
340												
341		**Office of Bureau Chief**										
342		010	048	78730000	000	404820	Federal Funds	$ 125				
343		010	048	78730000			Other Funds	$ -				
344		010	048	78730000			General Funds	$ 375	$ 375			
345		Total Revenue						$ 500				
346												
347		010	048	78730000	039	500190	Telecommunications	$ 500			$ 375	
348		Total Expense						$ 500				$ 375
349												
350		**Health Promotion Contracts**										
351		010	048	89170000	000	404160	Federal Funds	$ 500				
352		010	048	89170000			Other Funds	$ -				
353		010	048	89170000			General Funds	$ -	$ -			
354		Total Revenue						$ 500				
355												
356		010	048	89170000	041	500801	Audit Set Aside	$ 500			$ -	
357		Total Expense						$ 500				$ -
358												
359		**Money Follows the Person**										
360		010	048	89200000	000	404848	Federal Funds	$ 4,250				
361		010	048	89200000			Other Funds	$ -				
362		010	048	89200000			General Funds	$ -	$ -			
363		Total R	Telecommunications					$ 4,250				
364												
365		010	048	89200000	039	500190	Telecommunications	$ 3,700			$ -	
366		010	048	89200000	041	500801	Audit Set Aside	$ 550			$ -	
367		Total Expense						$ 4,250				$ -
368												
369		**Medicaid Services Grants - SHIP**										
370		010	048	89250000	000	403839	Federal Funds	$ 1,000				

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
371		010	048	89250000			Other Funds	$ -				
372		010	048	89250000			General Funds	$ -	$ -			
373		Total Revenue						$ 1,000				
374												
375		010	048	89250000	039	500190	Telecommunications	$ 500			$ -	
376		010	048	89250000	041	500801	Audit Set Aside	$ 500			$ -	
377		Total Expense						$ 1,000				$ -
378												
379		**Long Term Care Ombudsman**										
380		010	048	89300000	000	404476	Federal Funds	$ 500				
381		010	048	89300000			Other Funds	$ -				
382		010	048	89300000			General Funds	$ -	$ -			
383		Total Revenue						$ 500				
384												
385		010	048	89300000	041	500801	Audit Set Aside	$ 500			$ -	
386		Total Expense						$ 500				$ -
387												
388		**Nursing Staff**										
389		010	048	89310000	000	404674	Federal Funds	$ 1,250				
390		010	048	89310000			Other Funds	$ -				
391		010	048	89310000			General Funds	$ 750	$ 750			
392		Total Revenue						$ 2,000				
393												
394		010	048	89310000	039	500190	Telecommunications	$ 1,500			$ 750	
395		010	048	89310000	041	500801	Audit Set Aside	$ 500			$ -	
396		Total Expense						$ 2,000				$ 750
397												
398		**Nursing Home Auditors**										
399		010	048	89320000	000	404675	Federal Funds	$ (102,250)				
400		010	048	89320000			Other Funds	$ -				
401		010	048	89320000			General Funds	$ (102,250)	$ (102,250)			
402		Total Revenue						$ (204,500)				
403												
404		010	048	89320000	010	500100	Personal Services - Permanent	$ (145,000)			$ (72,500)	
405		010	048	89320000	012	500128	Personal Services - Unclassifie	$ (60,000)			$ (30,000)	
406		010	048	89320000	039	500190	Telecommunications	$ 500			$ 250	
407		Total Expense						$ (204,500)				$ (102,250)
408												
409		**Field Operations**										
410		010	04[illegible]	92500000	000	404825	Federal Funds	$ 2,375				
411		010	[illegible]	92500000			Other Funds	$ -				

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
412		010	048	92500000			General Funds	$ 10,625	$ 10,625			
413		Total Revenue						$ 13,000				
414												
415		010	048	92500000	039	500190	Telecommunications	$ 12,500			$ 10,625	
416		010	048	92500000	041	500801	Audit Set Aside	$ 500				
417		Total Expense						$ 13,000				$ 10,625
418												
419		**Social Services Block Grant**										
420		010	048	92550000	000	404373	Federal Funds	$ 654,380				
421		010	048	92550000			Other Funds	$ -				
422		010	048	92550000			General Funds	$ (644,080)	$ (644,080)			
423		Total Revenue						$ 10,300				
424												
425		010	048	92550000	041	500801	Audit Set Aside	$ 10,300			$ -	
426		010	048	92550000	543	500385	Adult In Home Care	$ 644,080			$ -	
427		010	048	92550000	543	500385	Adult In Home Care	$ (644,080)			$ (644,080)	
428		Total Expense						$ 10,300				$ (644,080)
429												
430		**Servicelink**										
431		010	048	95650000	000		Federal Funds	$ -				
432		010	048	95650000			Other Funds	$ -				
433		010	048	95650000			General Funds	$ 3,000	$ 3,000			
434		Total Revenue						$ 3,000				
435												
436		010	048	95650000	039	500190	Telecommunications	$ 3,000			$ 3,000	
437		Total Expense						$ 3,000				$ 3,000
438												
439		**TOTAL BUREAU OF ELDERLY AND ADULT SERVICES**								**$ (672,180)**		**$ (672,180)**
440												
441	**DIVISION OF COMMUNITY BASED CARE SERVICES**											
442												
443		**Director's Office**										
444		010	049	29830000	000	404678	Federal Funds	$ (53,000)				
445		010	049	29830000			Other Funds	$ -				
446		010	049	29830000			General Funds	$ (212,000)	$ (212,000)			
447		Total Revenue						$ (265,000)				
448												
449		010	049	29830000	010	500100	Personal Services - Permanent	$ (210,000)			$ (168,000)	
450		010	049	29830000	012	500128	Personal Services - Unclassifie	$ (55,000)			$ (44,000)	
451		Total Expense						$ (265,000)				$ (212,000)

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
452												
453		**TOTAL DIVISION OF COMMUNITY BASED CARE SERVICES**								**$ (212,000)**		**$ (212,000)**
454												
455	**DIVISION OF PUBLIC HEALTH SERVICES**											
456												
457		**FAMILY PLANNING**										
458		010	090	55300000	000	404700	Federal Funds	$ -				
459		010	090	55300000			Other Funds	$ -				
460		010	090	55300000			General Funds	$ (35,304)	$ (35,304)			
461		Total Revenue						$ (35,304)				
462												
463		010	090	55300000	102	500731	Contracts for Program Services	$ (35,304)			$ (35,304)	
464		Total Expense						$ (35,304)				$ (35,304)
465												
466		**TOTAL DIVISION OF PUBLIC HEALTH SERVICES**								**$ (35,304)**		**$ (35,304)**
467												
468	**GLENCLIFF HOME**											
469												
470		**Professional Care**										
471		010	091	57100000	000		Federal Funds	-				
472		010	091	57100000			Other Funds	-				
473		010	091	57100000			General Funds	(48,319)	$ (48,319)			
474		Total Revenue						(48,319)				
475												
476		010	091	57100000	010	500100	Personal Services Perm Clas	$ (28,319)			$ (28,319)	
477		010	091	57100000	020	500200	Current Expense	$ 20,000			$ 20,000	
478		010	091	57100000	024	500225	Maint Other Than Bldg&Grnds	$ (10,000)			$ (10,000)	
479		010	091	57100000	046	500464	Consultant	$ (10,000)			$ (10,000)	
480		010	091	57100000	101	500729	Medical Payments to Provider	(20,000)			$ (20,000)	
481		Total Expense						(48,319)				$ (48,319)
482												
483		**Custodial**										
484		010	091	57200000	000		Federal Funds	-				
485		010	091	57200000			Other Funds	-				
486		010	091	57200000			General Funds	(62,968)	$ (62,968)			
487		Total Revenue						(62,968)				
488												
489		010	091	57200000	010	500100	Personal Services Perm Clas	$ (35,000)			$ (35,000)	
490		010	091	57200000	017	500147	FT-Employee-Special Pmt	$ (19,968)			$ (19,968)	
491		010	091	57200000	050	500109	Personal Services-Temp	$ (3,000)			$ (3,000)	
492		010	[illegible]	57200000	024	500225	Maint Other Than Bldg&Grnds	(5,000)			$ (5,00[illegible]	

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
493		Total Expense						(62,968)				$ (62,968)
494												
495		**Maintenance**										
496		010	091	78920000	000		Federal Funds	-				
497		010	091	78920000			Other Funds	-				
498		010	091	78920000			General Funds	100,000	$ 100,000			
499		Total Revenue						100,000				
500												
501		010	091	78920000	048	500226	Contractual Maint Bldg & Grns	100,000			$ 100,000	
502		Total Expense						100,000				$ 100,000
503												
504		**TOTAL GLENCLIFF HOME**								**$ (11,287)**		**$ (11,287)**
505												
506	**BUREAU OF BEHAVIORAL HEALTH**											
507												
508		**TTI Grant**										
509		010	092	18490000	000	400146	Federal Funds	$ 740				
510		010	092	18490000			Other Funds	$ -				
511		010	092	18490000			General Funds	$ -	$ -			
512		Total Revenue						$ 740				
513												
514		010	092	18490000	080	500710	Out of State Travel	$ 740			$ -	
515		Total Expense						$ 740				$ -
516												
517		**Consumer and Family Affairs**										
518		010	092	30680000	000		Federal Funds	$ -				
519		010	092	30680000			Other Funds	$ -				
520		010	092	30680000			General Funds	$ -	$ -			
521		Total Revenue						$ -				
522												
523		010	092	30680000	020	500200	Current Expenses	$ 500			$ 500	
524		010	092	30680000	021	502668	Food Institutions	$ (500)			$ (500)	
525		Total Expense						$ -				$ -
526												
527		**CMH Program Support**										
528		010	092	59450000	000	408147	Federal Funds	$ -				
529		010	092	59450000			Other Funds	$ -				
530		010	092	59450000			General Funds	$ -	$ -			
531		Total Revenue						$ -				
532												
533		010	092	59450000	020	500200	Current Expenses	$ (1,200)			$ (792)	

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
534		010	092	59450000	039	500188	Telecommunications	$ 1,200			$ 792	
535		Total Expense						$ -				$ -
536												
537		**TOTAL BUREAU OF BEHAVIORAL HEALTH**								$ -		$ -
538												
539	**BUREAU OF DEVELOPMENTAL SERVICES**											
540												
541		**Special Medical Services**										
542		010	093	51910000	000	404599	Federal Funds	$ -				
543		010	093	51910000			Other Funds	$ -				
544		010	093	51910000			General Funds	$ -	$ -			
545		Total Revenue						$ -				
546												
547		010	093	51910000	039	500191	Telecommunications	$ 4,500			$ 3,150	
548		010	093	51910000	561	500911	Specialty Clinics	$ (4,500)			$ (3,150)	
549		Total Expense						$ -				$ -
550												
551		**Program Support**										
552		010	093	59470000	000	408148	Federal Funds	$ -				
553		010	093	59470000			Other Funds	$ -				
554		010	093	59470000			General Funds	$ -	$ -			
555		Total Revenue						$ -				
556												
557		010	093	59470000	020	500200	Current Expenses	$ (2,190)			$ (1,402)	
558		010	093	59470000	021	502668	Food Institutions	$ (510)			$ (326)	
559		010	093	59470000	039	500191	Telecommunications	$ 2,700			$ 1,728	
560		Total Expense						$ -				$ -
561												
562		**Medicaid Compliance**										
563		010	093	71670000	000	403795	Federal Funds	$ -				
564		010	093	71670000			Other Funds	$ -				
565		010	093	71670000			General Funds	$ -	$ -			
566		Total Revenue						$ -				
567												
568		010	093	71670000	030	500191	Equipment	$ (1,000)			$ (500)	
569		010	093	71670000	039	500191	Telecommunications	$ 1,000			$ 500	
570		Total Expense						$ -				$ -
571												
572		**Medicaid to Schools**										
573		010	093	71720000	000	403796	Federal Funds	$ 3,503,500				
574		010	[illegible]	71720000			Other Funds	$ -				

	A	B		D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
575		010	093	71720000			General Funds	$ -	$ -			
576		Total Revenue						$ 3,503,500				
577												
578		010	093	71720000	041	500801	Audit Set Aside	$ 3,500			$ -	
579		010	093	71720000	511	500351	Medicaid to Schools	$ 3,500,000			$ -	
580		Total Expense						$ 3,503,500				$ -
581												
582		**TOTAL BUREAU OF DEVELOPMENTAL SERVICES**								$ -		$ -
583												
584	**NEW HAMPSHIRE HOSPITAL**											
585												
586		**WORKERS COMPENSATION**										
587		010	094	81360000			General Funds	$ (203,105)	$ (203,105)			
588		Total Revenue						$ (203,105)				
589												
590		010	094	81360000	062	500538	Workers Comp	$ (203,105)			$ (203,105)	
591		Total Expense						$ (203,105)				$ (203,105)
592												
593		**ADMINISTRATION**										
594		010	094	84000000	000	404444	Federal Funds	$ (47,100)				
595							General Funds	$ (88,900)	$ (88,900)			
596		Total Revenue						$ (136,000)				
597												
598												
599		010	094	84000000	010	500100	Personal Services - Permanent	$ (125,000)			$ (87,500)	
600		010	094	84000000	042	500620	Addl Fringe Benefits	$ (9,000)			$ -	
601		010	094	84000000	070	500700	In State Travel Reimburs	$ (2,000)			$ (1,400)	
602		Total Expense						$ (136,000)				$ (88,900)
603												
604		**NHH FACILITY/PATIENT SUPPORT**										
605		010	094	84100000	000	404448	Federal Funds	$ 76,290				
606		010	094	84100000	009	407550	Other Funds: Café	$ -				
607							General Funds	$ 247,710	$ 247,710			
608		Total Revenue						$ 324,000				
609												
610		010	094	84100000	023	500266	Heat Electric Water	$ 120,000			$ 82,800	
611		010	094	84100000	042	500620	Addl Fringe Benefits	$ (35,000)			$ -	
612		010	094	84100000	047	500240	Own Force Maint	$ 40,000			$ 27,600	
613		010	094	84100000	048	500226	Contractual Maint Build/Grnd	$ 199,000			$ 137,310	
614		Total Expense						$ 324,000				$ 247,710
615												

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
616												
617		**Acute Psychiatric Services**										
618		010	094	87500000	000	404434	Medicaid DSH	$ (713,510)				
619		010	094	87500000	009	405921	Other Funds	$ (750,531)				
620		010	094	87500000			General Funds	$ (470,960)	$ (470,960)			
621		Total Revenue						$ (1,935,001)				
622												
623		010	094	87500000	010	500100	Personal Services - Permanent	$ (1,200,000)			$ (324,000)	
624		010	094	87500000	012	500128	Personal Services - Unclass	$ (450,000)			$ (121,500)	
625		010	094	87500000	042	500620	Addl Fringe Benefits	$ (190,000)			$ -	
626		010	094	87500000	066	500544	Employee Training	$ (15,000)			$ (4,020)	
627		010	094	87500000	101	500729	Medical Pymts to Providers	$ (80,000)			$ (21,440)	
628		Total Expense						$ (1,935,000)				$ (470,960)
629												
630		**TOTAL NEW HAMPSHIRE HOSPITAL**								**$ (515,255)**		**$ (515,255)**
631												
632	**OFFICE OF COMMISSIONER**											
633												
634		**Office of Commissioner**										
635		010	095	50000000	000	403900	Federal Funds	$ (16,239)				
636		010	095	50000000			Other Funds	$ -				
637		010	095	50000000			General Funds	$ (10,761)	(10,761)			
638		Total Revenue						(27,000)				
639												
640		010	095	50000000	039	500188	Telecommunications	(17,000)			$ (10,761)	
641		010	095	50000000	042	500620	Add'l Fringe Benefit	(10,000)			$ -	
642		Total Expense						(27,000)				(10,761)
643												
644		**Employee Assistance Program**										
645		010	095	50250000	000	403900	Federal Funds	$ (192)				
646		010	095	50250000			Other Funds	$ -				
647		010	095	50250000			General Funds	$ (2,808)	(2,808)			
648		Total Revenue						(3,000)				
649												
650		010	095	50250000	039	500188	Telecommunications	1,000			$ 936	
651		010	095	50250000	066	500544	Training	(1,000)			$ (936)	
652		010	095	50250000	070	500704	In-State Travel	(3,000)			$ (2,808)	
653		Total Expense						(3,000)				(2,808)
654												
655		**Office of Business Operations**										
656		010		56760000	000	403970	Federal Funds	$ (82,750)				

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
657		010	095	56760000			Other Funds	$ -				
658		010	095	56760000			General Funds	$ (92,250)	(92,250)			
659		Total Revenue						(175,000)				
660												
661		010	095	56760000	010	500100	Perm - Classified	(170,000)			$ (104,550)	
662		010	095	56760000	012	500128	Perm - Unclassified	(40,000)			$ (24,600)	
663		010	095	56760000	020	500200	Current Expense	75,000			$ 46,125	
664		010	095	56760000	042	500620	Add'l Fringe Benefit	(25,000)			$ -	
665		010	095	56760000	050	500109	Personnel - Temporary	(15,000)			$ (9,225)	
666		Total Expense						(175,000)				(92,250)
667												
668		**Homeland Security**										
669		010	095	71780000	000	403900	Federal Funds	$ -				
670		010	095	71780000	009	407079	Other Funds	$ (35,000)				
671		010	095	71780000			General Funds	$ -				
672		Total Revenue						(35,000)				
673												
674		010	095	71780000	020	500200	Current Expense	(500)			$ -	
675		010	095	71780000	030	500311	Equipment	(25,000)			$ -	
676		010	095	71780000	039	500188	Telecommunications	(2,500)			$ -	
677		010	095	71780000	070	500704	In-State Travel	(5,000)			$ -	
678		010	095	71780000	080	500714	Out-State Travel	(2,000)			$ -	
679		Total Expense						(35,000)				-
680												
681		**TOTAL OFFICE OF THE COMMISSIONER**								**$ (105,819)**		**$ (105,819)**
682												
683	**OFFICE OF ADMINISTRATION**											
684												
685		**Bureau Human Resource**										
686		010	095	56770000	000	403971	Federal Funds	$ (60,630)				
687		010	095	56770000			Other Funds	$ -				
688		010	095	56770000			General Funds	$ (129,870)	(129,870)			
689		Total Revenue						(190,500)				
690												
691												
692		010	095	56770000	010	500100	Perm - Classified	(175,000)			$ (129,500)	
693		010	095	56770000	020	500200	Current Expense	(2,000)			$ (1,480)	
694		010	095	56770000	039	500188	Telecommunications	1,000			$ 740	
695		010	095	56770000	042	500620	Add'l Fringe Benefit	(15,000)			$ -	
696		010	095	56770000	070	500704	In-State Travel	500			$ 370	
697		Total Expense						(190,500)				(129,870)

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
698												
699		**Management Support**										
700		010	095	56850000	000	400716	Federal Funds	$ (26,210)				
701		010	095	56850000			Other Funds	$ -				
702		010	095	56850000			General Funds	$ (32,790)	(32,790)			
703		Total Revenue						(59,000)				
704												
705		010	095	56850000	020	500200	Current Expense	41,000			$ 24,600	
706		010	095	56850000	022	500248	Rents & Leases other than Stat	(250,000)			$ (150,000)	
707		010	095	56850000	024	500225	Contract Repairs;Machin-Equip	(10,000)			$ (6,000)	
708		010	095	56850000	028	500292	Transfers to General Services	20,000			$ 12,000	
709		010	095	56850000	039	500188	Telecommunications	40,000			$ 24,000	
710		010	095	56850000	103	502664	Contracts for Operational Servi	100,000			$ 62,610	
711		Total Expense						(59,000)				(32,790)
712												
713		**DHHS District Office**										
714		010	095	56870000	000	404717	Federal Funds	$ 37,000				
715		010	095	56870000			Other Funds	$ -				
716		010	095	56870000			General Funds	$ 78,000	78,000			
717		Total Revenue						115,000				
718												
719		010	095	56870000	039	500188	Telecommunications	130,000			$ 78,000	
720		010	095	56870000	042	500620	Add'l Fringe Benefit	(15,000)			$ -	
721		Total Expense						115,000				78,000
722												
723		**TOTAL OFFICE OF ADMINISTRATION**								**$ (84,660)**		**$ (84,660)**
724												
725	**OFFICE OF INFORMATION SERVICES**											
726												
727		**Office of Improvement and Integrity**										
728		010	095	59520000	000	408159	Federal Funds	$ 12,195,357				
729		010	095	59520000			Other Funds	$ -				
730		010	095	59520000			General Funds	$ 2,980,313	$ 2,980,313			
731		Total Revenue						$ 15,175,670				
732												
733		010	095	59520000	040	500800	Indirect	$ 20,000			$ -	
734		010	095	59520000	041	500801	Audit Fund Set Aside	$ 24,950			$ -	
735		010	095	59520000	027	502799	Transfers to OIT	$ 700,000			$ 420,000	
736		010	095	59520000	102	500731	Contracts for Prog.Svs	$ 14,430,720			$ 2,560,313	
737		Total Expense						$ 15,175,670				$ 2,980,313
738												

	A	B	C	D	E	F	G	H	I	J	K	L
1		Fund	Agcy	Org	Cla	Rcpt	Class Title	Increase/	Net Gen'l	Net Gen'l		
2						Acc't		Decrease	Fund by	Fund By	GF	
3								Amount	Org. Code	Agency	Amount	S/T
739		**TOTAL OFFICE OF INFORMATION SERVICES**								**$ 2,980,313**		**$ 2,980,313**
740												
741								**Total DHHS**		**$ -**	**$ -**	**$ -**
742												

	Transfer Summary - General Funds Only	DCYF	OMHRA	BHHS	DCSS	DFA	DCS	OMBP	BEAS	DCBCS	DPHS	GHE
10	Personal Services	0	0	0	0	(181,000)	0	0	(72,500)	(168,000)	0	(63,319)
012	Full-Time Unclassified	0	0	0	0	0	0	0	(30,000)	(44,000)	0	0
017	FT Employee-Special Pmt	0	0	0	0	0	0	0	0	0	0	(19,968)
18	Overtime	0	0	0	0	0	0	0	0	0	0	0
19	Holiday	0	0	0	0	0	0	0	0	0	0	0
02*	Current Expense/Utilities	0	0	0	0	(4,563)	23,530	0	3,000	0	0	5,000
30	Equipment	0	0	0	0	0	0	0	0	0	0	0
37	Technology-Hardware	0	0	0	0	0	0	0	0	0	0	0
039	Telecommunications	0	640	1,000	0	(14,805)	15,338	0	19,500	0	0	0
040	Indirect	0	0	0	0	0	0	0	0	0	0	0
41	Audit Fund Set Aside	0	0	0	0	0	0	0	0	0	0	0
42	Additional Fringe	0	0	0	0	0	0	0	0	0	0	0
45	Personal Serv-Non Ben	0	0	0	0	0	0	0	0	0	0	0
46	Consultants	0	0	0	0	0	0	0	0	0	0	(10,000)
47	Own Forces	0	0	0	0	0	0	0	0	0	0	0
48	Cont Maint	0	0	0	0	0	0	0	0	0	0	100,000
49	Trans Other Agency	0	0	0	0	0	0	0	0	0	0	0
05*	Temporary Personnel	0	0	0	0	0	0	0	0	0	0	(3,000)
60	Benefits	0	0	0	0	0	0	0	0	0	0	0
061	Unemployment Compensation	0	0	0	0	0	0	0	0	0	0	0
062	Workers Compensation	0	0	0	0	0	0	0	0	0	0	0
066	Employee Training	0	0	0	0	0	0	0	0	0	0	0
067	Other Personnel Costs	0	0	0	0	0	0	0	0	0	0	0
068	Remuneration	0	0	0	0	0	0	0	0	0	0	0
70	In State Travel	0	(640)	0	0	0	0	0	0	0	0	0
072	Grants Federal	0	0	0	0	0	0	0	0	0	0	0
073	Grants Non-Federal	0	0	0	0	0	0	0	0	0	0	0
87	Home Health	0	0	0	0	0	0	0	0	0	0	0
80	Out of State Travel	0	0	0	0	0	0	0	0	0	0	0
89	Outpatient Hospital-BEAS	0	0	0	0	0	0	0	0	0	0	0
100	Prescription Drug Exp	0	0	0	0	0	0	(50,000)	0	0	0	0
101	Medical Payments to Providers	0	0	0	0	0	0	18,750	0	0	0	(20,000)
102	Contracts for Program Services	0	0	(1,000)	0	(1,175,322)	0	58,272	0	0	(35,304)	0
103	Contracts for Operational Services	0	0	0	0	(469,000)	0	0	0	0	0	0
108	Provider Payments Legal Services	0	0	0	0	0	0	0	0	0	0	0
230	Interpreter Services	0	0	0	0	0	0	0	0	0	0	0
246	GranteeAdministration cost	0	0	0	0	0	0	0	0	0	0	0
501	Payment to Clients	0	0	0	0	440,000	0	0	0	0	0	0
502	Payment to Providers	0	0	0	0	3,742	0	0	0	0	0	0
503	State Phase Down	0	0	0	0	0	0	0	0	0	0	0
504	Nursing Home Payment	0	0	0	0	0	0	0	0	0	0	0
505	Mid Level Care Expenses	0	0	0	0	0	0	0	0	0	0	0
506	Home Nursing Services	0	0	0	0	0	0	0	189,200	0	0	0

		DCYF	OMHRA	BHHS	DCSS	DFA	DCS	OMBP	BEAS	DCBCS	DPHS	GHE
509	Other Nursing Services	0	0	0	0	0	0	0	0	0	0	0
511	Medicaid to Schools	0	0	0	0	0	0	0	0	0	0	0
512	Transportation of Clients	0	0	0	0	0	0	0	0	0	0	0
518	MMA Supplemental Assistance	0	0	0	0	0	0	0	0	0	0	0
521	Food Rebate	0	0	0	0	0	0	0	0	0	0	0
523	Client Benefit	0	0	0	0	0	0	0	0	0	0	0
525	Cedarcrest	0	0	0	0	0	0	0	0	0	0	0
526	Specialty Hospital- Pediatrics	0	0	0	0	0	0	0	0	0	0	0
529	Home Health Services	0	0	0	0	0	0	0	(212,300)	0	0	0
530	Drug Rebates	0	0	0	0	0	0	0	0	0	0	0
533	Foster Care Services	0	0	0	0	0	0	0	0	0	0	0
534	Adoption Services	0	0	0	0	0	0	0	0	0	0	0
535	Out of Home Placements	0	0	0	0	0	0	0	0	0	0	0
537	Education Supplies	0	0	0	0	0	0	0	0	0	0	0
539	Payments to Towns & Cities	0	0	0	0	0	0	0	0	0	0	0
542	Homemaker	0	0	0	0	0	0	0	0	0	0	0
543	Adult In Home Care	0	0	0	0	0	0	0	(644,080)	0	0	0
546	Patient Care	0	0	0	0	0	0	0	0	0	0	0
547	Disease Control Emergencies	0	0	0	0	0	0	0	0	0	0	0
548	Reagents	0	0	0	0	0	0	0	0	0	0	0
550	Assessment and Counseling	0	0	0	0	0	0	0	0	0	0	0
557	Waiver Services	0	0	0	0	0	0	0	0	0	0	0
558	Waitlist	0	0	0	0	0	0	0	0	0	0	0
559	Catastrophic Aid	0	0	0	0	0	0	0	0	0	0	0
560	Transportation of Clients	0	0	0	0	0	0	0	0	0	0	0
561	Specialty Clinics	0	0	0	0	0	0	0	0	0	0	0
562	CSHCN	0	0	0	0	0	0	0	0	0	0	0
563	Community Based Services	0	0	0	0	0	0	0	0	0	0	0
565	Outpatient Hospital	0	0	0	0	0	0	(8,750)	75,000	0	0	0
566	Adult Group Daycare	0	0	0	0	0	0	0	0	0	0	0
568	HIV CARE Boston EMA	0	0	0	0	0	0	0	0	0	0	0
GF	SOF Mix Change	0	0	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	(1,400,948)	38,868	18,272	(672,180)	(212,000)	(35,304)	(11,287)

	Transfer Summary - General Funds Or							
		BBH	BDS	NHH	OCOM	OADM	OIS	Total
10	Personal Services	0	0	(411,500)	(104,550)	(129,500)	0	(1,130,369)
012	Full-Time Unclassified	0	0	(121,500)	(24,600)	0	0	(220,100)
017	FT Employee-Special Pmt	0	0	0	0	0	0	(19,968)
18	Overtime	0	0	0	0	0	0	0
19	Holiday	0	0	0	0	0	0	0
02*	Current Expense/Utilities	(792)	(1,728)	82,800	46,125	(120,880)	420,000	452,492
30	Equipment	0	(500)	0	0	0	0	(500)
37	Technology-Hardware	0	0	0	0	0	0	0
039	Telecommunications	792	5,378	0	(9,825)	102,740	0	120,758
040	Indirect	0	0	0	0	0	0	0
41	Audit Fund Set Aside	0	0	0	0	0	0	0
42	Additional Fringe	0	0	0	0	0	0	0
45	Personal Serv-Non Ben	0	0	0	0	0	0	0
46	Consultants	0	0	0	0	0	0	(10,000)
47	Own Forces	0	0	27,600	0	0	0	27,600
48	Cont Maint	0	0	137,310	0	0	0	237,310
49	Trans Other Agency	0	0	0	0	0	0	0
05*	Temporary Personnel	0	0	0	(9,225)	0	0	(12,225)
60	Benefits	0	0	0	0	0	0	0
061	Unemployment Compensation	0	0	0	0	0	0	0
062	Workers Compensation	0	0	(203,105)	0	0	0	(203,105)
066	Employee Training	0	0	(4,020)	(936)	0	0	(4,956)
067	Other Personnel Costs	0	0	0	0	0	0	0
068	Remuneration	0	0	0	0	0	0	0
70	In State Travel	0	0	(1,400)	(2,808)	370	0	(4,478)
072	Grants Federal	0	0	0	0	0	0	0
073	Grants Non-Federal	0	0	0	0	0	0	0
87	Home Health	0	0	0	0	0	0	0
80	Out of State Travel	0	0	0	0	0	0	0
89	Outpatient Hospital-BEAS	0	0	0	0	0	0	0
100	Prescription Drug Exp	0	0	0	0	0	0	(50,000)
101	Medical Payments to Providers	0	0	(21,440)	0	0	0	(22,690)
102	Contracts for Program Services	0	0	0	0	0	2,560,313	1,406,959
103	Contracts for Operational Services	0	0	0	0	62,610	0	(406,390)
108	Provider Payments Legal Services	0	0	0	0	0	0	0
230	Interpreter Services	0	0	0	0	0	0	0
246	GranteeAdministration cost	0	0	0	0	0	0	0
501	Payment to Clients	0	0	0	0	0	0	440,000
502	Payment to Providers	0	0	0	0	0	0	3,742
503	State Phase Down	0	0	0	0	0	0	0
504	Nursing Home Payment	0	0	0	0	0	0	0
505	Mid Level Care Expenses	0	0	0	0	0	0	0
506	Home Nursing Services	0	0	0	0	0	0	189,200

		BBH	BDS	NHH	OCOM	OADM	OIS	Total
509	Other Nursing Services	0	0	0	0	0	0	0
511	Medicaid to Schools	0	0	0	0	0	0	0
512	Transportation of Clients	0	0	0	0	0	0	0
518	MMA Supplemental Assistance	0	0	0	0	0	0	0
521	Food Rebate	0	0	0	0	0	0	0
523	Client Benefit	0	0	0	0	0	0	0
525	Cedarcrest	0	0	0	0	0	0	0
526	Specialty Hospital- Pediatrics	0	0	0	0	0	0	0
529	Home Health Services	0	0	0	0	0	0	(212,300)
530	Drug Rebates	0	0	0	0	0	0	0
533	Foster Care Services	0	0	0	0	0	0	0
534	Adoption Services	0	0	0	0	0	0	0
535	Out of Home Placements	0	0	0	0	0	0	0
537	Education Supplies	0	0	0	0	0	0	0
539	Payments to Towns & Cities	0	0	0	0	0	0	0
542	Homemaker	0	0	0	0	0	0	0
543	Adult In Home Care	0	0	0	0	0	0	(644,080)
546	Patient Care	0	0	0	0	0	0	0
547	Disease Control Emergencies	0	0	0	0	0	0	0
548	Reagents	0	0	0	0	0	0	0
550	Assessment and Counseling	0	0	0	0	0	0	0
557	Waiver Services	0	0	0	0	0	0	0
558	Waitlist	0	0	0	0	0	0	0
559	Catastrophic Aid	0	0	0	0	0	0	0
560	Transportation of Clients	0	0	0	0	0	0	0
561	Specialty Clinics	0	(3,150)	0	0	0	0	(3,150)
562	CSHCN	0	0	0	0	0	0	0
563	Community Based Services	0	0	0	0	0	0	0
565	Outpatient Hospital	0	0	0	0	0	0	66,250
566	Adult Group Daycare	0	0	0	0	0	0	0
568	HIV CARE Boston EMA	0	0	0	0	0	0	0
GF	SOF Mix Change	0	0	0	0	0	0	0
	Total	0	0	(515,255)	(105,819)	(84,660)	2,980,313	0

DEPARTMENT OF HEALTH AND HUMAN SERVICES
TRANSFER OF FUNDS SFY 2014 – OTHER EXPENDITURES

DIVISION FOR CHILDREN, YOUTH & FAMILIES

05-95-042-421410-79060000
OJJDP

Funding in this organization represents costs associated with the Jail Compliance Monitor and Program Specialist positions, as well as programs funded by the Formula, Challenge, and Title V grants from the Office of Juvenile Justice & Delinquency Prevention (OJJDP) for prevention and intervention. Funds are available in class 072 (Grants Federal) to help a projected deficit in OJJDP Title V Grant in the Division. Source of funds: 100% Federal.

05-95-042-421410-79080000
OJJDP Title V

Funding in this organization represents costs associated with Title V grants from the Office of Juvenile Justice & Delinquency Prevention (OJJDP) for prevention and intervention. Funds are needed in class 072 (Grants Federal) due to budget shortage. Source of funds: 100% Federal.

OFFICE OF MINORITY HEALTH ABD REFUGEE AFFAIRS

05-95-042-422010-79210000
Office of Minority Health and Refugee Affairs

Funding in this organization represents costs associated with the operation of the Office of Minority Health and Refugee Affairs, which administers the programs, and policies that reduce health disparities in minority and refugee communities throughout the State. Funds are required in Telecommunications (class 039) and Audit Fees (class 041) to cover a deficit in the account, there is a corresponding availability of funds in In-State Travel (class 070). Source of funds for this transfer reflect the anticipated federal revenues from cost allocation earnings.

05-95-042-422010-79220000
Refugee Services

Funding in this organization represents costs associated with Refugee grants as awarded from the Office of Refugee Resettlement. Funds are required in Telecommunications (class 039) as funds required exceeds the amount budgeted in SFY 2014. Source of Funds: 100% Federal (Refugee Resettlement Grants).

05-95-042-422010-79230000
OMH Partnership Grant

Funding in this organization represents costs associated with the operation of the Office of Minority Health, which administers the programs, and policies that reduce health disparities in minority communities throughout the State. Funds are required in Telecommunications (class 039) and are offset by available funds in Employee Training (class 066). Source of Funds is 100% Federal from the Minority Health State Partnership Grant.

05-95-042-422010-79240000
Health Professional Opportunity Grant

Funding in this organization represents costs associated with the Health Professional Opportunity grant to assist low-income individuals with education and training for occupations in the healthcare field. Funds are required in Audit Fees (class 041) as amount needed exceeds the amount budgeted. Source of Funds: 100% Federal (HPOP Grant).

DIVISION OF HOMELESS HOUSING SERVICES

05-95-042-423010-79270000
Housing Shelter Program

This accounting unit is the operating account for the US Department of Housing and Urban Development grants to the Bureau of Homeless and Housing Services (BHHS). Funds are available in Contracts for Program Services (class 102) to help a projected deficit in Part-time Salary (Class 050) line item. Source of Funds is 100% Federal from US Department of Housing and Urban Development grants.

05-95-042-423010-79280000
Emergency Shelter Program

Funding in this organization represents costs associated with the operation of the Bureau of Homeless and Housing Services, which administers the State's Emergency Shelter programs and US Department of Housing and Urban Development homeless assistance programs. Funds are required in Telecommunications (class 039) to align appropriations with projected expenditures. Funds are available in Contracts for Program Services (class 102) due an Emergency Shelter Program recipient not accepting funds made available to them, and due to an across the board cut of just under 1% to all providers with a State Grant-In-Aid contract. Source of Funds is 100% General.

DIVISION OF CHILD SUPPORT SERVICES

05-95-042-427010-79290000
Child Support Services

Funding in this organization represents the costs associated with the operation of the Division of Child Support Services. Funds are available in Additional Fringe Benefits (class 042) to help a projected deficit in Audit Funds Set Aside (class 041). Source of Funds: 100% Federal

DIVISION OF FAMILY ASSISTANCE

05-95-045-450010-61250000
Director's Office

Funding in this organization represents costs associated with the administration of the Division and its programs. This transfer decreases Class 039, Telecommunications. This transfer will take projected surplus to help fund projected deficits in the Division within the same class line. Additionally source of funds for expense class lines are being adjusted to reflect actual earnings. Source of Funds: 48% Federal Funds, 52% General Funds.

05-95-045-450010-61270000
Employment Support

Funding in this organization represents costs associated with the administration of the New Hampshire Employment Program (NHEP). This transfer decreases Class 020, Current Expenses, Class 039, Telecommunications and Class 102, Contracts for Program Services. This transfer also increases Class 502, Payments to Providers. The transfers for Class 020, 039 and 102 will take projected surplus to help fund projected deficits in the Division. The transfer for Class 502 is needed due to expenses being higher than anticipated when budgeted. This transfer will satisfy the projected shortfalls. Source of Funds (Class 020): 54% Federal Funds, 46% General Funds, Source of Funds (Class 039): 51% Federal Funds, 49% General Funds, Source of Funds (Class 102): 43% Federal Funds, 57% General Funds, Source of Funds (Class 502): 63% Federal Funds, 37% General Funds.

05-95-045-450010-61530000
Separate State TANF

Funding in this organization represents costs associated with the Separate State TANF Grants. Funds are required in Class 501, Payments to Clients, due to caseloads being higher than anticipated when budgeted. This transfer will satisfy the projected shortfalls. Source of Funds: 100% General Funds.

05-95-045-450010-61700000
Age Assistance Grants

Funding in this organization represents costs associated with the Age Assistance Grants. Funds are required in Class 501, Payments to Clients, due to caseloads being higher than anticipated

when budgeted. This transfer will satisfy the projected shortfalls. Source of Funds: 100% General Funds.

05-95-045-450010-61740000
APTD

Funding in this organization represents costs associated with the Aid to the Permanently and Totally Disabled (APTD) cash assistance grant. Funds are required in Class 501, Payments to Clients, due to caseloads being higher than anticipated when budgeted. This transfer will satisfy the projected shortfalls. Source of Funds: 100% General Funds.

DIVISION OF CLIENT SERVICES

05-95-045-451010-79930000
DFA Field Svcs

Funding in this organization represents costs associated with the staff in the district offices providing direct services to the clients of New Hampshire. This transfer increases Class 020, Current Expenses, Class 041 Audit Fees and Class 039, Telecommunications. The transfers for Class 020, Class 041 and Class 039 are needed due to expenses being higher in these class lines than anticipated when budgeted. Source of Funds: 48% Federal Funds, 52% General Funds

05-95-045-451010-79940000
DCYF FLD OPS PG ELB

Funding in this organization code represents the costs associated with the eligibility determination/revenue enhancement staff for DCYF. This transfer increases Class 039, Telecommunications. The transfer for Class 039 is needed due to expenses being higher than anticipated when budgeted. This transfer will satisfy the projected shortfalls. Source of Funds: 40% Federal Funds, 60% General Funds.

05-95-045-451010-79960000
Client Elig & Enrollment Operations

Funding in this appropriation primarily represents costs associated with the management and operation of Medicaid programs serving citizens throughout New Hampshire. This transfer decreases 039, Telecommunications. The transfer for Class 039 will take projected surplus to help fund projected deficits in the Division. Source of Funds: 50% Federal, 50% General

05-95-045-451010-79970000
Disability Determination Unit

Funding in this organization primarily represents costs associated with the Disability Determination Unit serving citizens throughout New Hampshire. This transfer decreases Class

020, Current Expenses. The transfer for Class 020 will take projected surplus to help fund projected deficits in the Division. Source of Funds: 50% Federal, 50% General

OFFICE OF MEDICAID & BUSINESS POLICY

05-95-047-470010-79370000
Medicaid Administration

Funding in this appropriation represents costs associated with the management and operation of Medicaid programs serving citizens throughout New Hampshire. Funds are needed in Class 041, Audit Set Aside to cover an anticipated shortfall in this account for the remainder of the fiscal year due to costs associated with Health Protection Program. Source of Funds: 100% Federal

05-95-047-470010-79400000
Provider Payments

Funding in this appropriation represents costs associated with the Medicaid payments to healthcare providers that deliver healthcare services to New Hampshire's Medicaid population. There is a surplus in Class 100 Prescription Drug Expenses as costs and utilization have been less than originally projected. The transfer request will be used to satisfy the projected deficit in the Family Planning account to cover related costs associated with the NH Family Planning Medical Assistance Program. Source of Funds: Class 041 Audit Set-aside 100% Federal and Class 100 Prescription Drug Expenses 50% Federal, 50% General.

05-95-047-470010-79410000
BCC Program

Funding in this organization represents costs associated with the Medicaid payments to healthcare providers that deliver healthcare services to New Hampshire's Medicaid population. There is a surplus in Class 565 Outpatient Hospital due to lower than projected costs. These surplus funds will be used to cover a projected deficit in Class 101 Medical Payments to Provider due to higher than anticipated costs for these services. Source of Funds: Class 041 Audit Set-aside 100% Federal; Class 101 Medical Payments to Providers 65% Federal, 35% General; Class 565 Outpatient Hospital, 65% Federal, 35% General.

05-95-047-470010-79420000
Family Planning

Funding in this organization represents costs associated with the Medicaid payments to healthcare providers to deliver family planning services provided under the NH Family Planning Medical Assistance Program. Funds are needed in class 101, Medical Payments to Providers to cover family planning medical expenses. This is a new program implemented July 1, 2013 and the need and utilization for these services year-to date have been higher than what was originally

projected. Source of Funds: Class 041 Audit Set-aside 100% Federal and Class 101 Medical Payments to Providers 90% Federal, 10% General

05-95-047-470010-79480000
Medicaid Care Management
Funding in this appropriation represents costs associated with the Medicaid payments to healthcare providers that deliver healthcare services to New Hampshire's Medicaid population as part of the Care Management Program. Funds are needed to cover additional contract costs encumbered in this account. Source of Funds: Class 041 Audit Set-aside 100% Federal and Class 102 Contracts for Program Services 90% Federal, 10% General

BUREAU OF ELDERLY AND ADULT SERVICES

05-95-048-481010-33170000
Admin On Aging Svcs Grants - Smpp

Funding in this organization represents costs associated with administering grants received from the Administration for Community Living (ACL – formerly Administration on Aging (AoA)). Funds are needed in Class 041 (Audit Set Aside) to satisfy projected deficits. Source of Funds: 100% Federal.

05-95-048-481510-59420000
Nursing Services – County Participation

Funding in this organization represents costs associated with providing long term care services for the elderly and adults with disabilities. These services include: Nursing Homes, Mid-level Care, Home Support Waiver Services and Home Health Care Waiver Services. Funds are needed in Class 041 (Audit Set Aside) to satisfy projected deficits. In addition, funds are needed in Class 506 (Home Support Waiver Services) due to greater than anticipated utilization in Personal Care Services. Funds are available in Class 529 (Home Health Care Waiver Services) due to less than anticipated utilization of Home Health Care Waiver Services. Source of Funds: 100% Federal (Class 041); 50.84% Federal, 42.28% Other & 6.88 General (Class 506); & 50% Federal, 42.28% Other & 7.72% General (Class 529).

05-95-048-481510-59430000
Proshare

Funding in this organization represents costs associated with the supplemental payment to county nursing homes. Funds are needed in Class 041 (Audit Set Aside) to satisfy projected deficits. Source of Funds: 100% Federal.

05-95-048-481510-59440000
Medicaid Quality Incentive Payment

Funding in this organization represents costs associated with the supplemental Medicaid Quality Incentive Payment made to acuity based nursing facilities. Funds are needed in Class 041 (Audit Set Aside) to satisfy projected deficits. Source of Funds: 100% Federal.

05-95-048-481510-61730000
Nursing Services

Funding in this organization represents Medicaid provider payments associated with providing care for the elderly and adults with disabilities. Funds are needed in Class 565 (Outpatient Hospital) to satisfy a higher than anticipated utilization of services. Source of Funds: 50% Federal, 50% General.

05-95-048-481510-61800000
LTC Assessment & Counseling

Funding in this organization represents Medicaid funded expenditures for contracted services to Medicaid applicants to nursing facilities and home and community based care services for assessment & counseling and to provide assistance, information and education to consumers, families and the community. Funds are needed in Class 039 (Telecommunications) due to a projected deficit as a result of additional VoIP Expenditures not anticipated; and, Class 041 (Audit Set Aside) to satisfy projected deficits. Source of Funds: 100% Federal (Class 041) & 50% Federal, 50% General (Class 039).

05-95-048-481510-78560000
Medicaid Administration

Funding in this organization represents costs associated with the administration of all Medicaid Services. Funds are needed in Class 039 (Telecommunications) due to a projected deficit as a result of additional VoIP Expenditures not anticipated. Source of Funds: 50% Federal, 50% General.

05-95-048-481010-78720000
Administration On Aging

Funding in this organization represents costs associated with administering grants received from the Administration for Community Living (ACL – formerly Administration on Aging (AoA)). Funds are needed in Class 020 (Current Expense), due to additional expenditures not accounted for in the budget; and, Class 039 (Telecommunications) due to a projected deficit as a result of additional VoIP Expenditures not anticipated. Source of Funds: 100% General.

05-95-048-480010-78730000
Office Of Bureau Chief

Funding in this organization represents costs associated with overseeing all aspects of the Bureau of Elderly and Adult Services. Funds are needed in Class 039 (Telecommunications) due to a projected deficit as a result of additional VoIP Expenditures not anticipated. Source of Funds: 25% Federal, 75% General.

05-95-048-481010-89170000
Health Promotion Contracts

Funding in this organization represents costs associated with administering grants received from the Administration for Community Living (ACL – formerly Administration on Aging (AoA)). Funds are needed in Class 041 (Audit Set Aside) to satisfy projected deficits. Source of Funds: 100% Federal.

05-95-048-481010-89200000
Money Follows The Person

Funding in this organization represents costs associated with providing transitional programs to home and community based care clients transitioning from the nursing home. Funds are needed in Class 039 (Telecommunications) due to a projected deficit as a result of additional VoIP Expenditures not anticipated, and Class 041 (Audit Fund Set Aside) to satisfy projected deficits. Source of Funds: 100% Federal.

05-95-048-481010-89250000
Medicaid Services Grants - Ship

Funding in this organization represents costs associated with the administration and oversight of grants related to Medicaid Services. Funds are needed in Class 039 (Telecommunications) due to a projected deficit as a result of additional VoIP Expenditures not anticipated. Funds are also needed in Class 041 (Audit Set Aside) to satisfy projected deficits. Source of Funds: 100% Federal.

05-95-048-480510-89300000
Long Term Care Ombudsman

Funding in this organization represents costs associated with providing long term care ombudsman services and to administrating grants received from the Administration for Community Living (ACL – formerly Administration on Aging (AoA)). Funds are needed in Class 041 (Audit Set Aside) to satisfy projected deficits. Source of Funds: 100% Federal.

05-95-048-480510-89310000
Nursing Staff

Funding in this organization represents costs associated with registered nurses evaluating clinical information to determine whether applicants meet the clinical eligibility standard for long term care services. In addition the nursing staff determines if the appropriate community based services, to meet the needs identified during the clinical assessment process, are being received by the applicant. They also provide clinical risk management and oversight of case management services. Funds are needed in Class 039 (Telecommunications) due to a projected deficit as a result of additional VoIP Expenditures not anticipated, and Class 041 (Audit Fund Set Aside) to satisfy projected deficits. Source of Funds: 50% Federal, 50% General (Class 039) & 100% Federal (Class 041).

05-95-048-481510-89320000
Nursing Home Auditors

Funding in this organization represents costs associated with the administration and oversight of rate setting for services provided and audits/reviews of Medicaid and contracted providers, including nursing homes. Funds are available in Class 010 (Personal Services – Permanent) and Class 012 (Personal Services – Unclassified) due to vacancies. Funds are needed in Class 039 (Telecommunications) due to a projected deficit as a result of additional VoIP Expenditures not anticipated. Source of Funds: 50% Federal, 50% General.

05-95-048-480510-92500000
Field Operations

Funding in this organization represents costs associated with direct social services to elderly and incapacitated adults. Funds are needed in Class 039 (Telecommunications) to satisfy projected deficits due to the mobile technology initiative and addition VoIP expenditures in this accounting unit. In addition, funds are needed in Class 041 (Audit Fund Set Aside) to satisfy projected deficits. Source of Funds: 15% Federal, 85% General (Class 039) & 100 % Federal (Class 041).

05-95-048-481010-92550000
Social Services Block Grant

Funding in this organization represents costs associated with administering the social service block grant award. Funds are needed in Class 041 (Audit Fund Set Aside) to satisfy projected deficits. Additionally source of funds for class 543 are being adjusted to reflect actual earnings Source of Funds: 100% Federal.

05-95-048-481010-95650000
Servicelink

Funding in this organization represents expenditures for contracted services to Medicaid applicants to nursing facilities and home and community based care services for assessment & counseling and to provide assistance, information and education to consumers, families and the

community. Funds are needed in Class 039 (Telecommunications) due to a projected deficit as a result of additional VoIP Expenditures not anticipated. Source of Funds: 100% General.

DIVISION OF COMMUNITY BASED CARE SERVICES

05-95-049-490510-29830000
DIRECTOR'S OFFICE

Funding in this organization represents costs associated with Division of Community Based Care Services Director's Office. Funds are available in Class 010 (Personal Services – Permanent) and Class 012 (Personal Services – Unclassified) due to vacancies. Source of Funds: 80% General and 20% Federal.

DIVISION OF PUBLIC HEALTH SERVICES

05-95-090-902010-55300000
Family Planning Program

Funding in this organization represents costs associated with the Family Planning Program within the Division of Public Health Services. Available funds have been identified in Class 102 (Contracts for Program Services).
Source of Funds: 100% General

GLENCLIFF HOME

05-95-091-910010-57100000
Professional Care

Funding in this organization represents costs associated with Professional Care Services delivered to clients. Funds are available in Class 010 (Personal Services – Permanent), Class 024 (Maint. Other Than Bldg & Grnds), Class 046(Consultant) and Class 101(Medical Payments to Provider) due to expenses less than budgeted. Funds are needed in Class 020(Current Expense) due to the need of additional clinical supplies.
Source of Funds: 100% General

05-95-091-910010-57200000
Custodial Care

Funding in this organization represents costs associated with the Dietary, Housekeeping and Laundry Services of Glencliff Home. Funds are available in Class 010 (Personnel Perm), Class 017 (FT-Employee-Special Pmt) and Class 050 (Personal Services-Tem) due to vacancies and Class 024(Maint.Other Than Bldg & Grnds) due to continued efficiencies.
Source of Funds: 100% General

05-95-091-910010-78920000
Maintenance

Funding in this organization represents costs associated with the Maintenance Department. Funds are needed in Class 048(Contractual Maintenance of Buildings and Grounds) due to two, critical projects-Move Electrical Transformers From Vacant Building and Rebuild the Elevator in the Warehouse.
Source of Funds: 100% General

BUREAU OF BEHAVIORAL HEALTH

05-95-092-920010-18490000
TTI Grant

Funding in this accounting unit represents costs associated with the TTI Grant. Funds are needed in Class 080 (Out of State Travel) to cover an anticipated deficit. Source of Funds: 100% Federal.

05-95-092-920010-30680000
Consumer And Family Affairs

Funding in this accounting unit represents costs associated with the Office of Consumer and Family Affairs. Funds are needed in Class 020 (Current Expenses) due to greater than anticipated expenses. Funds are available in Class 021 (Food Institutions) as expenses have been less than anticipated. Source of Funds: 100% General.

05-95-092-920010-59450000
Cmh Program Support

Funding in this accounting unit represents operational costs associated the Office of Community Mental Health Services. Funds are needed in Class 039 (Telecommunications) due to VOIP charges that were unanticipated during budgeting. Funds are available in Class 020 (Current Expenses) as expenses have been less than anticipated. Source of Funds: 66% General and 34% Federal.

BUREAU OF DEVELOPMENTAL SERVICES

05-95-093-930010-51910000
Special Medical Services

Funding in this organization represents costs associated with the Special Medical Services unit within the Bureau of Developmental Services. Funds are needed in Class 039

(Telecommunications) to cover unanticipated additional VOIP expenses. Funds are available in Class 561 (Specialty Clinics) due to less than anticipated expenses. Source of Funds: 70% General, 30% Federal.

05-95-093-930010-59470000
Program Support

Funding in this organization represents costs associated with the operation of the Community Developmental Services central office within the Bureau of Developmental Services. Funds are needed in Class 039 (Telecommunications) to cover unanticipated additional VOIP expenses. Funds are available in Class 020 (Current Expenses) and Class 021 (Food Institutions) due to less than anticipated expenses. Source of Funds: 64% General, 36% Federal.

05-95-093-930010-71670000
Medicaid Compliance

Funding in this organization represents costs associated with the unit that issuance of prior authorizations to Medicaid Providers for Medicaid Waiver services. Funds are needed in Class 039 (Telecommunications) to cover unanticipated additional VOIP expenses. Funds are available in Class 030 (Equipment) due to less than anticipated expenses. Source of Funds: 50% General, 50% Federal.

05-95-093-930010-71720000
Medicaid To Schools

Funding in this organization represents costs associated with the Medicaid to Schools Program. Funds are needed in Class 511 (Medicaid to Schools) to cover an anticipated shortfall caused by Medicaid billing greater than expected when the budget was created. Source of Funds: 100% Federal.

NEW HAMPSHIRE HOSPITAL

05-95-094-940010-81360000
Workers Compensation

Funding in this organization represents costs associated with the Workers Compensation Insurance for New Hampshire Hospital. Due to lower than anticipated work related injuries, appropriations in Class 062 (Workers Compensation) are greater than necessary. Source of Funds: 100% General.

05-95-094-940010-84000000
Administration

Funding in this organization represents costs associated with the administration of New Hampshire Hospital. Funds are available in Class 010 (Personnel – Perm) due to vacancies. Funds appropriated for Class 042 (Addl Fringe Benefits) and Class 070 (Instate Travel Reimbursement) are greater than the projected need. Source of Funds: Class 042 - 100% Federal, Class 010 and 070 - 30% Federal, 70% General.

05-95-094-940010-84100000
NHH-Facility/Patient Support

Funding in this organization represents costs associated with the operation of New Hampshire Hospital, Facility/Patient Support Services. Staff in these areas provides direct services to patients in Food and Nutritional Services, Environmental Services, Laundry Services and Maintenance. Funds appropriated in class 042 (Addl Fringe Benefits) is greater than anticipated due to vacant positions. Funds are necessary in Class 023 (Heat, Electric, Water) due to higher costs of services throughout the winter months. In addition, Class 047 (Own Force Maintenance Buildings –Grounds), Class 048 (Contractual Maintenance Buildings –Grounds), to cover unanticipated repairs necessary to maintain the Acute Psychiatric Services building. Source of Funds: Cls 042 – 100% Federal, Other Classes - 31% Federal, 69% General.

05-95-094-940010-87500000
ACUTE PSYCHIATRIC SERVICES

Funding in this organization represents costs associated with the operation of New Hampshire Hospital, Acute Psychiatric Services. These costs cover the direct expenses of supporting patients. Funds appropriated to the following classes are available due to lower than anticipated need for the designated services: Class 010 (Personnel – Perm), Class 012 (Personnel – Unclassified), Class 042 (Addl Fringe Benefits), Class 066 (Employee Training) and Class 101 (Medical Payments to Providers). Source of Funds: 30% Federal, 43% Other and 27% General.

OFFICE OF THE COMMISSIONER

05-95-095-950010-50000000
Office of the Commissioner

Funding in this organization represents costs associated with the operation of the Commissioner's Office. Funds are available in Telecommunications (class 039) and Additional Fringe Benefits (class 042) to offset a need in the Office of Business Operations. Source of funds for this transfer reflect the anticipated federal revenues from cost allocation earnings.

05-95-095-950010-50250000
Employee Assistance Program

Funding in this organization represents costs associated with the operation of this program that provides assistance to employees who are having problems in their work or personal lives by helping them secure appropriate assistance. Funds are needed in Telecommunications (class 039) because actual costs exceed the adjusted authorized for SFY 2014 and are offset by available funds in Training (class 066). Additionally funds are available in In State travel (class 070) due to budgeted amount exceeds actual amount needed. Source of funds for this transfer reflect the anticipated federal revenues from cost allocation earnings.

05-95-095-950010-56760000
Office of Business Operations

Funding in this organization represents costs associated with the operation of the Office of Business Operations. Funds are available in permanent personnel services (class 010) and Unclassified Personnel (class 012) because adjusted authorized exceeds the cost for currently filled positions. Funds are needed in Current Expense (class 020) because actual costs exceed the adjusted authorized for SFY 2014, a portion of this need is offset by available funds in the Commissioner's Office. Funds are available in Additional Fringe Benefits (class 042) and Personal Services Temporary (class 050) due to budgeted amount exceeds actual amount needed. Source of funds for this transfer reflect the anticipated federal revenues from cost allocation earnings.

05-95-095-950010-71780000
Homeland Security

Funding in this organization represents costs associated with maintaining an emergency preparedness capability as required by the Radiological Emergency Response Plan (RERP) and NH RSA 107-B, Nuclear Planning and Response Program. Funds are available in Current Expense, Telecommunications, In-State Travel, and Out of State Travel (classes 020, 039, 070, 080) to align the state budget with the awarded budget from Department of Safety. Source of Funds: 100% Other (Dept of Safety).

OFFICE OF ADMINISTRATION

05-95-095-953010-56770000
Bureau of Human Resources

Funding in this organization represents costs associated with the management of Human Resources and Payroll operations within the Department. Funds are available in permanent personnel services (class 010) because adjusted authorized exceeds the cost for currently filled positions. Funds are available in Current Expense (class 020) and Fringe Benefits (class 042) as adjusted authorized exceeds funds required. Funds are required in Telecommunications (class 039) and In-State Travel (class 070) because actual costs exceed the adjusted authorized for SFY 2014. Source of funds for this transfer reflect the anticipated federal revenues from cost allocation earnings.

05-95-095-953010-56850000
Management Support

Funding in this organization represents costs associated with the management of the facilities operations within the Department. This includes both the various locations in Concord and the District Office's throughout the State. Funds are available in Rents and Leases (class 022) and Contract Repairs (class 024) due to amount budgeted for SFY 2014 exceeding the amount needed. Funds are required in Current Expense, Transfers to General Services, Telecommunications and Contracts for Operational Services (classes 020, 028, 039 and 103) to fund anticipated shortfalls in the accounts. Source of funds for this transfer reflect the anticipated federal revenues from cost allocation earnings.

05-95-095-953010-56870000
DHHS District Office
Funding in this organization represents costs for staff in the District Offices throughout the State that perform the administrative and programmatic activities, and community relations, on behalf of employees, clients and providers. Funds are required in Telecommunications (class 039) to fund the VOIP phone bills in the District Offices. Funds are available in Fringe Benefits (class 042) as adjusted authorized exceeds the amount needed due to vacant positions. Source of funds for this transfer reflect the anticipated federal revenues from cost allocation earnings.

OFFICE OF INFORMATION SERVICES

05-95-095-954010-59520000
Office of Information Services

Funding in this organization code represents the costs associated with the staff of the Office of Information Services that provide a range of information technology management services across the Department of Health and Human Services. In addition, funding in this office is for the Department of Information Technology expenses in support of the Department of Health and Human Services and the Medicaid Management Information System. This transfer will fund a projected deficit in Indirect Costs and Audit Fund Set Aside due to higher than anticipated federal fund related expenses. Additional funds are needed in Class 027 (Transfers to OIT) to fund additional costs related to New Heights Maintenance and Operations. The transfer will fund a projected deficit in Contracts for Program Services that is due to increased costs for the Medicaid Management Information System due to development and operations costs for federally mandated system enhancements. Source of funds: 100% Federal Funds for Indirect Costs and Audit Fund Set Aside. 40% Federal Funds and 60% General Funds for Transfers to OIT. 82% Federal Funds and 18% General Funds for Contracts for Program Services.