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State/Territory Name: New York

State Plan Amendment (SPA) #: NY-22-0032-CHIP

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- 1) Approval Letter
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Children and Adults Health Programs Group

April 15, 2022

Gabrielle Armenia
CHIP Director
Office of Health Insurance Programs
State of New York Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237-0004

Dear Ms. Armenia:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number NY-22-0032-CHIP, submitted on March 31, 2022, has been approved. Through this SPA, New York has demonstrated compliance with the American Rescue Plan Act of 2021 (ARP). This SPA has an effective date of March 11, 2021 and extends through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period, as described in section 1135(g)(1)(B) of the Social Security Act.

Section 9821 of the ARP amended sections 2103(c)(11)(B) and 2103(e)(2) of the Act to mandate coverage of COVID-19 testing, treatment, and vaccines and their administration without cost-sharing or amount, duration, or scope limitations. Sections 2103(c)(11)(B) and 2103(e)(2) of the Act also require states to cover, without cost sharing, the treatment of conditions that may seriously complicate COVID-19 treatment, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19. The state provided the necessary assurances to demonstrate compliance with the ARP in accordance with the requirements of sections 2103(c)(11)(B) and 2103(e)(2) of the Act.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 457.65 that the state submit SPAs that are related to the COVID-19 public health emergency by the end of the state fiscal year in which they take effect. CMS is allowing states that submit SPAs after the last day of the state fiscal year to have an effective date in the prior state fiscal year, but no earlier than the effective date of the public health emergency. New York requested a waiver to obtain an earlier effective date of March 11, 2021.

Pursuant to section 1135(b)(5) of the Act, CMS is also allowing states to modify the timeframes associated with tribal consultation required under section 2107(e)(1)(f) of the Act, including shortening the number of days before submission or conducting consultation after submission of the SPA. New York requested a waiver to modify the tribal consultation policy by completing tribal consultation in the fiscal year after the effective date of the SPA.

This letter approves New York’s request for a March 11, 2021 effective date and provides the state with the authority to modify the tribal consultation policy.

Your title XXI project officer is Shakia Singleton. She is available to answer questions concerning this amendment and other CHIP-related issues. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8102
E-mail: Shakia.Singleton@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Division Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Amy
Lutzky/

Amy Lutzky
Deputy Director
On Behalf of Anne Marie Costello, Deputy Director
Center for Medicaid and CHIP Services

cc: Courtney Miller, Director, Medicaid and CHIP Operations Group
Jackie Glaze, Deputy Director, Medicaid and CHIP Operations Group

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

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

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

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b)) /s/ Gabrielle Armenia
(Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Name: _____	Position/Title: _____
Name: _____	Position/Title: _____
Name: _____	Position/Title: _____

Disclosure Statement This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children’s Health Insurance Program (CHIP). In February 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

This template outlines the information that must be included in the state plans and the State plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
 - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
 - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
 - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
 - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
 - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
 - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
 - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)

States are not required to resubmit existing State plans using this current updated template. However, States must use this updated template when submitting a new State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90-day

review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a “clean” copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children’s Health Insurance Plans and the Requirements-** This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination-** This section should provide general information related to the special characteristics of each state’s program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls-** This section requires the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children’s Health Insurance-** Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided

must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care-** This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration-** The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations-** Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low-income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity-** In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e)); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections-** This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of

eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements

States expanding through Medicaid-only will also be required to submit a Medicaid State plan amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes

of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under “Option to Expand Medicaid” would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in “Option to Create a Separate Program” would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Where the state’s assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

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

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

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

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

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State’s Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

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

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State’s Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

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

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

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

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

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The

implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

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

Original Plan

Original Submission

Submission date:	November 15, 1997
Effective date:	April 15, 2003
Implementation date:	April 15, 2003

SPA #1

Submission date:	March 26, 1998
Denial:	April 1, 1998
Reconsideration:	May 26, 1998(Withdrawn)

SPA #2

Submission date:	March 30, 1999
Effective date:	January 1, 1999
Implementation date	January 1, 1999

SPA #3

Submission date:	March 21, 2001
Effective date:	April 1, 2000
Implementation date:	April 1, 2000

SPA #4

Submission date:	March 27, 2002
Effective date:	April 1, 2001
Implementation date:	April 1, 2001

SPA #5 (compliance)

Submission date:	March 31, 2003
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SPA #6 (renewal process)
 Submission date: March 22, 2004
 Effective date: April 1, 2003
 Implementation date: April 1, 2003

SPA #7
 Submission date: March 17, 2005
 Effective date: April 1, 2004 (Updates to State Plan)
 April 1, 2005 (Phase-out of Medicaid
 Expansion Program)
 Implementation date: April 1, 2004 (Updates to State Plan)
 April 1, 2005 (Phase-out of Medicaid
 Expansion Program)

SPA #8
 Submission date: March 28, 2006
 Effective date: April 1, 2005
 Implementation date: August 1, 2005

SPA #9
 Submission date: March 28, 2007
 Effective date: April 1, 2006
 Implementation date: April 1, 2006

SPA # 10
 Submission date: April 3, 2007
 Effective date: April 1, 2007
 Implementation date: April 1, 2007
 -general information
 Implementation date (Proposed): September 1, 2007
 Implementation date (Actual): September 1, 2008
 -expansion, substitution strategies
 Denied: September 7, 2007
 Petition for Reconsideration: October 31, 2007
 Stayed: March 17, 2009

SPA # 11
 Submission date: May 14, 2007
 Effective date: September 1, 2007
 Implementation date: September 1, 2007

SPA # 12
 Submission date: March 18, 2009
 Effective date: September 1, 2008
 Implementation date: September 1, 2008

SPA # 13
Submission date: June 30, 2009
Effective date: April 1, 2009
Implementation date: April 1, 2009

SPA # 14
Submission date: July 6, 2009
Effective date: July 1, 2009
Implementation date: July 1, 2009

SPA # 15
Submission date: March 29, 2010
Effective date: April 1, 2009
Implementation date: April 1, 2009

SPA # 16
Submission date: March 21, 2011
Effective date: April 1, 2010
Implementation date: April 1, 2010

SPA # 17
Submission date: May 20, 2011
Effective date (Enrollment Center): June 13, 2011
Effective date (Medical Homes Initiative): October 1, 2011
Implementation date: June 13, 2011

SPA # 18
Submission date: September 20, 2011
Effective date: August 25, 2011
Implementation date: August 25, 2011

SPA # 19
Submission date: March 22, 2012
Effective date (Medicaid Expansion): November 11, 2011
Implementation date: November 11, 2011

SPA # 20
Submission date: March 31, 2014
Effective date (autism benefit): April 1, 2013
Effective date (other ACA changes): January 1, 2014
Implementation date: April 1, 2013 and January 1, 2014

SPA #21	
Submission date:	March 31, 2015
Effective date:	April 1, 2014
Implementation date:	April 1, 2014
SPA #NY-16-0022- C-A	
Submission date:	March 28, 2016
Effective date: (HSI for Poison Control Centers and Sickle Cell Screening):	April 1, 2015
Effective date (Ostomy Supplies):	May 1, 2015
Implementation date:	April 1, 2015 and May 1, 2015
SPA #NY-17-0023 – C - A	
Submission date:	March 31, 2017
Effective date (HSI Opioid Drug Addiction and Opioid Overdose Prevention Program for Schools, Hunger Prevention Nutrition Assistance Program (HPNAP))	April 1, 2016
Effective date (Coverage for Newborns):	January 1, 2017
Implementation date:	April 1, 2016 and January 1, 2017
SPA #NY – 19-0024	
Submission date:	March 27, 2019
Effective date (Transition of Children to NY State of Health):	
Effective Date (Allowing Children to Recertify on the Last Day of the Month of their Enrollment Period):	
Implementation Date:	April 1, 2018
SPA # NY -19-0025	
Submission date:	March 28, 2019
Removal of the 90 day Waiting Period.	
Effective Date:	April 1, 2018
Implementation Date:	April 1, 2018

SPA #NY- 20-0026– *Pending Approval*
Submission Date: March 18, 2020
Effective Date Mental Health
Parity Compliance: April 1, 2019
Implementation Date: April 1, 2019

SPA #NY- 20-0027– *Pending Approval*
Submission Date: March 31, 2020
Effective Date: Compliance with
Managed Care Regulations April 1, 2019
Implementation Date: April 1, 2019

SPA #NY- 20-0028
Submission Date: March 31, 2020
Effective Date: Disaster Relief
Provisions March 1, 2020
Implementation Date: March 1, 2020

SPA #NY- 20-0029
Submission Date: June 25, 2020
Effective Date: (HSI Early
Intervention Program)
Provisions April 1, 2020
Implementation Date: April 1, 2020

SPA #NY- 21-0030 – *Pending Approval*
Submission Date: March 31, 2021
Effective Date: Support Act
Provisions April 1, 2020
Implementation Date: April 1, 2020

SPA #NY- 21-0031-CHIP- *Pending Approval*
Submission Date: March 31, 2022
Effective Date Ends Manual Process
to Remove Children from the Child
Health Plus Waiting period: July 15, 2021
Implementation Date: July 15, 2021

SPA #NY- 21-0032-CHIP

Submission Date:

March 31, 2022

Effective Date: Compliance with
the American Rescue Plan Act
of 2021:

March 11, 2021

Implementation Date:

March 11, 2021

Superseding Pages of MAGI CHIP State Plan Material

State: New York

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
NY-14-0001	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low-Income Children	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3
Effective/Implementation Date: January 1, 2014		CS15	MAGI-Based Income Methodologies	Incorporate within a separate subsection under section 4.3
NY-14-0002	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
Effective/Implementation Date: January 1, 2014				
NY-14-0003	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
Effective/Implementation Date: January 1, 2014				
NY-13-0004	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
Effective/Implementation Date: October 1, 2013				
NY-14-0005	Non-Financial Eligibility	CS17	Residency	Supersedes the current section 4.1.5
Effective/Implementation Date: January 1, 2014		CS18	Citizenship	Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR
		CS19	Social Security Number	Supersedes the current section 4.1.9.1
		CS20		Supersedes the current section 4.4.4
		CS21	Substitution of Coverage	Supersedes the current section 8.7
		CS27	Non-Payment of Premiums	Supersedes the current section 4.1.8
	CS28	Continuous Eligibility	Supersedes the current section 4.3.2	
	General Eligibility			

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
			Presumptive Eligibility for Children	
NY-19-0025 Effective/Implementation Date: April 1, 2018	Non-Financial Eligibility	CS20	Substitution of Coverage	Supersedes the previously approved CS20.

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

Consistent with New York’s approved tribal consultation policy, a letter was mailed to all federally recognized tribes in New York State on June 9, 2020 notifying them of the proposed State Plan Amendment. A link was provided in the letter for purposes of allowing the tribes to view the proposed State Plan Amendment. The tribes were given two weeks to provide comments/feedback on the proposed State Plan Amendment. No feedback was received within the prescribed timeframe.

TN No: Approval Date Effective Date

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

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified)

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

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

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

New York proposes to cover the following programs under the Health Services Initiatives provision:

1. EARLY INTERVENTION PROGRAM

Program Details

Description

The New York State Early Intervention Program (“program”) is part of the national Early Intervention Program for infants and toddlers with disabilities and their families. It was created by Congress in 1986 under the Individuals with Disabilities Education Act (IDEA). In New York, the program was established in Article 25 of the Public Health Law and has been in effect since July 1, 1993. The New York State Department of Health (“Department”) is designated as the lead agency for the state and is responsible for general administration, supervision and oversight of the program. The program is managed within the Department by the Bureau of Early Intervention.

The mission of the program is to identify and evaluate as early as possible those infants and toddlers whose healthy development is compromised and provide for appropriate intervention to improve the family and child’s development. The program is family-centered and supports parents in meeting their responsibility to nurture and enhance their child’s development. The program serves approximately 70,000 children. The Department enters into agreements with providers who deliver the program’s services. There are about 1,300 providers under agreement, with approximately 18,000 qualified personnel rendering services to children and their families.

Eligibility

To be eligible for services, a child must be under three years of age and have a confirmed disability or established developmental delay. A disability means that a child has a diagnosed physical or mental condition that may lead to developmental problems. These include, but are not limited to, autism, Down syndrome, motor disorders, or vision and hearing problems. A developmental delay signifies that a child is behind in some area of development, such as growth, learning and thinking, or communicating.

Services

The program offers a variety of therapeutic and support services to eligible infants and toddlers with disabilities and their families, including: family education and counseling; home visits; parent support groups; special instruction; speech pathology and audiology; occupational therapy; physical therapy; psychological services; service coordination; nursing services; nutrition services; social work services; vision services; and assistive technology devices and services. These services help the family learn the best ways to care for the infant/toddler, support and promote the child's development, and include the child in family and community activities.

The program is community-based. It creates opportunities for full participation of children with disabilities and their families in their communities by ensuring services are delivered in natural environments to the maximum extent appropriate. The services are provided anywhere in the community where the child typically spends their day, including the home; the child-care center or family day care home; community/recreational centers, play groups, playgrounds, libraries, or any place parents and young children go for fun and support; and early childhood programs and centers, such as Early Head Start.

Process

The program is administered locally by 57 counties and New York City. Each locality has an Intervention Official and a designated office responsible for administration and oversight of the program. Referral to the local office is the first step of the process. Parents may refer their own child if they have a concern about their child's development. In New York, certain professionals are also required to refer children to the program if a developmental problem is suspected.

After referral, the infant/toddler is evaluated by qualified professionals. If the child is eligible, the local program assists the parents in obtaining services. A specially designed written plan is developed for each child in the program. The plan outlines and explains the services the child and family will receive. An ongoing service coordinator is assigned to each case and facilitates and monitors the process. A transition plan is developed for the child as they approach their third birthday.

Budget Details

Funding Sources and Payment Details for Services

The program's services are provided at no cost to the parents. Services are financed through a combination of state funding, local funding and third-party payers (commercial insurance and Medicaid). Pursuant to state Public Health Law, billing providers must seek payment in the first instance from third-party payers to the extent that a child has private insurance regulated by the state or is enrolled in Medicaid. While services are funded from multiple sources, only the state funding will be considered for this health services initiative.

Providers submit claims for services rendered via the New York Early Intervention System (NYEIS) or through a secure portal supported by the program's state fiscal agent (SFA), the Public Consulting Group. The SFA submits the provider claims to applicable third-party payers and generates standardized municipal voucher for the services that are not covered by third-party payers. The local offices make payment for costs not covered by the third-party payers. The state reimburses the local offices a portion of their costs through voucher payments in SFS.

Department and Local Office Administration

State funding supports contracts with the local offices for payment of local administration of the program. In addition, federal Department of Education funding contributes to local administration and the Department's administration of the program. However, no administration payments will be considered for this Health Services Initiative.

Disbursements

Total program disbursements are projected at approximately \$165.0 million per year. Historically, payments to local offices for reimbursement of program services have accounted for approximately 98 percent of total program spending. The remaining 2 percent has funded contracts with the local offices for their administration of the program. The administration payments are excluded from this Health Services Initiative.

Appropriation

The program's state funding appropriation is located on page 747 in New York State's SFY 2020-21 Enacted Budget for State Operations. The appropriation totals \$165.0 million. The appropriation is in Center for Community Health Program major program within the Department's section of the budget bill. The funding source is the General Fund, Local Assistance account. The General Fund is the state's main operating fund.

General Ledger Journal Entries

With approval of this state plan amendment, general ledger journal entries will be processed in SFS to transfer eligible state funding Early Intervention Program disbursements to CHIP federal

funding. The Bureau of Budget Management (BBM) within the Department will initiate the general ledger journal entries in SFS. These transactions require a second level of approval within the Department and approval by the Office of the New York State Comptroller. BBM will attach appropriate backup documentation to the transactions. There are distinct program codes for the Early Intervention Program and CHIP, and there is a unique sub-program code within CHIP dedicated to health services initiatives. There are sub-program codes within Early Intervention to distinguish between services and administration expenditures. The applicable CHIP federal match rate for the quarter in which the original Early Intervention Program disbursement occurred will be used for the general ledger journal entries and for the claiming of these expenditures in the CMS-21 report.

Percentage Related to Children

As program eligibility is limited to individuals under age three, the entire population served is children under 18. Therefore, all Early Intervention disbursements will be considered related to children under 18. Total state funding program disbursements for a given period will be multiplied by the applicable CHIP federal matching rate to determine the amount eligible to be transferred to CHIP federal funding.

ASSURANCES

New York assures that the Early Intervention Program health services initiative described above will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds.

New York also assures the all (100 percent) of the funds transferred (state and federal) are retained by the Early Intervention Program.

2. Opioid Drug Addiction and Opioid Overdose Prevention Program for Schools

Program Details

Although there have been many successes in New York's community opioid overdose programs, deaths from overdose continue to climb. In 2013 there were 637 fatalities involving heroin throughout the State, or more than 12 deaths per week. Many overdoses occur with young people.

Since April 2006, New York State has had a program regulated by the Department of Health (the Department) through which eligible, registered entities provide training to individuals in the community on how to recognize an overdose and how to respond to it appropriately. The applicable law is Public Health Law Section 3309, and the regulations are found at Part 80 (80.138) of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York. These programs are administered within the Department by the Aids Institute.

The appropriate responses to an opioid overdose include calling 911 and administering naloxone (Narcan), an opioid antagonist which reverses the potentially life-threatening consequences of an overdose. Eligible entities include individual prescribers (physicians, physician assistants and nurse practitioners), drug treatment programs, health care facilities, local health departments (LDHs) and community-based organizations that have the services of clinical director.

Program funding is used to train individuals throughout the State as opioid overdose responders. The public health law was expanded in an amendment effective August 11, 2015 to specifically include school districts, boards of cooperative educational services, county vocational education and extension boards, charter schools and nonpublic elementary and/or secondary schools, as well as persons employed by these districts, boards or schools. As such, they are expressly authorized to respond to opioid overdoses through the administration of naloxone. Over 265 programs have registered with the Department, and approximately 100,000 overdose responders have been trained to date.

The opioid program provides education to school staff on how to be a responder using the kits. The school districts either register with the Department as opioid overdose prevention programs or they work with other eligible organizations that have chosen to register. Although elementary schools are included in the statutory language, the focus has been on middle and high schools. There is a curriculum and a mechanism for school staff to be trained in opioid overdose recognition and response. For clarification, the rescue kits are not distributed to the pupils, but rather to school personnel.

Program funding is also used to purchase opioid overdose prevention kits. Each kit is comprised of two mucosal atomizers, two syringes pre-filled with naloxone for use with the atomizers, a breathing mask, nitro gloves, and a zippered bag for containing the supplies. Naloxone has been successfully administered more than 2,700 times according to reports that have been submitted to the State. The actual number of reversals for which these responders have been responsible is likely to be substantially higher.

To carry out these objectives, the Department contracts with The Foundation for AIDS Research.

Payments to this vendor are for trainings, purchase of overdose prevention kits, and the contract's administrative expenses. These expenses include ordering the supplies, maintaining an inventory, interacting with the AIDS Institute, obtaining competitive pricing, providing reports on a regular basis, and working with pharmaceutical manufacturers and distributors. Overall program monitoring and assessing the achievement of goals involves review of monthly or quarterly narrative and statistical reports that are submitted, as well as onsite program and fiscal monitoring.

Budget and HSI Claiming Details

There are multiple funding sources for the program, two of which are Department appropriations, located within the Aids Institute major program. These are General Fund / Local Assistance appropriations, found in the Aid to Localities budget bill. The General Fund is the State's main operating fund.

Program estimates that 5% of gross expenditures relate to children age birth through 18. This figure will be used to approximate the total funding for children-related activity. Total expenses will be multiplied by 5% to establish the amount of funding related to children age birth through 18. This figure will then be multiplied by the current CHIP federal matching rate of 88% to calculate the amount of expenses that can be transferred to CHIP federal funding.

In the past, there has been a federal funding component of the program. The federal funds were an allocation and not a match. However, federal funds are not currently utilized. If federal funds are used prospectively, these funds will be excluded from the HSI, and only the State funds will be considered.

Periodic general ledger journal entries will be processed to move the qualified expenditures to CHIP federal funding. The expenses will be transferred from each fund source according to its percentage of the total funding. These transactions will be performed in the Statewide Financial System (SFS) and are approved within the Department, and at the Office of the State Comptroller (OSC). Backup documentation will be included when the journal entries are processed. There is distinct coding in SFS for the opioid program funding, and for CHIP funding. There is also a specific program code for CHIP HSI expenditures, to distinguish them from other CHIP expenditures.

Upon SPA approval, a general ledger journal entry or entries will be processed to charge CHIP federal funding for HSI-related expenditures retroactive to April 1, 2016, the effective date of the SPA. Prospectively, journal entries will be processed to transfer HSI-related expenditures to CHIP federal funding.

3. Hunger Prevention Nutrition Assistance Program (HPNAP)

Program Details

The Hunger Prevention and Nutrition Assistance Program (HPNAP) was established in 1984 as a result of public health concerns about nutrition-related illnesses among persons in need of food assistance. The program is authorized by Chapter 53, Section 1 of the Laws of 2016, and is administered within the Department by the Center for Community Health, Division of Nutrition, Bureau of Nutrition Risk Reduction. HPNAP provides emergency food relief and nutrition services

to food insecure populations in New York State.

HPNAP funding supports 46 Department contracts, which includes eight regional food banks and 38 direct service providers statewide. Through these contracts, approximately 240 million emergency meals are provided each year throughout the State. HPNAP works with an established network of more than 2,500 Emergency Food Programs (EFP, including food banks, food pantries and soup kitchens, to leverage private and public partnerships.

The goal of the program is to help New Yorkers in need lead healthier, productive and self-sufficient lives, which aligns with the HSI objective of helping low income populations. Access to a nutritious food supply directly improves the health of children. The program leads to increased access to safe and nutritious food and related resources, develops and provides nutrition and health education programs and empowers people to increase their independence from emergency food assistance programs.

Each regional food bank has a listing of the services they provide. These include safe and nutritious food to people in need; food transportation and food service equipment; assistance in gathering, processing and distributing unharvested fresh produce; nutrition and health information; and resources and guidance through workshops, handouts and site visits.

A component of the HPNAP program is the Just Say Yes to Fruits and Vegetables (JSY) program, a New York State program that offers nutrition education services to families with food insecurity. JSY is a collaboration between the Department and the New York State Regional Food Banks. It is designed to prevent over-weight/obesity and reduce long term chronic disease risks through the promotion of increased fruit and vegetable consumption. HPNAP and JSY work in partnership with EFPs to improve the health and nutrition status of people in need of food assistance in the State.

HPNAP maximizes service levels by utilizing the cost efficient emergency food relief network, and by closely monitoring contractor performance. All contractors receiving HPNAP funding must complete timely, accurate reports of monthly service levels, as specified in the HPNAP contract. In addition, HPNAP contract managers perform site visits for each of the program's 46 contractors each year.

Budget and HSI Claiming Details

The main funding source for the program is a Department appropriation, located within the Center for Community Health Program major program. The appropriation is General Fund / Local Assistance, and is in found in the Aid to Localities budget bill. The General Fund is the State's main operating fund.

During SFY 2015-16, the most recent period for which data are available, the number of children served age birth through 17 was 9,407,669, out of a total population served of 32,671,450. As such, it can be asserted that 28.7% of funding relates to children age birth through 18. Total HPNAP expenses will be multiplied by 28.7% to establish the amount of funding related to children age birth through 18. This figure will then be multiplied by the current CHIP federal matching rate of 88% to calculate the amount of expenses that can be transferred to CHIP federal funding.

The contracts associated with these programs use the State funded appropriation referenced above, but also a receive a small amount of federal funding through Nutrition-related grants. However, these federal funds are an allocation and not a match. For the purpose of the HSI, the federal funding allocation will be excluded and only the State funds will be considered.

Periodic general ledger journal entries will be processed to move the qualified expenditures to CHIP federal funding. These transactions will be performed in SFS, and are approved within the Department, and at OSC. Backup documentation will be included when the journal entries are processed. There is distinct coding in SFS for HPNAP funding, and for CHIP funding. There is also a specific program code for CHIP HSI expenditures, to distinguish them from other CHIP expenditures.

Upon SPA approval, a general ledger journal entry or entries will be processed to charge CHIP federal funding for HSI-related expenditures retroactive to April 1, 2016, the effective date of the SPA. Prospectively, journal entries will be processed to transfer HSI-related expenditures to CHIP federal funding.

Assurances

New York assures that the proposed HSI programs described above will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds.

New York also assures that all (100 percent) of the funds transferred (state and federal) are retained by the Opioid Drug Addiction and Opioid Overdose Prevention Program for Schools and the Hunger Prevention Nutrition Assistance Program (HPNAP).

4. Poison Control Centers

Program Details

DOH funds two regional poison control centers. New York City Regional Poison Control Center serves the Bronx, Brooklyn, Queens, Staten Island and Manhattan as well as Nassau, Suffolk and Westchester counties. Upstate New York Poison Center serves the 54 remaining counties of the state. Within DOH, the Office of Health Insurance Program's Division of Finance and Rate Setting administers the program.

The statutory authority for the program is contained in Sections 2500-d(7), 2807-j, and 2807-1(1)(c)(iv) of the Public Health (PHL), which authorizes the Commissioner to make distributions from the Health Care Initiatives (HCI) Pool to the Regional Poison Control Centers. This HCI Pool funding is intended to assist the centers with meeting the operational costs of providing expert poison call response and poison consultation services on a 24/7 basis to health care professionals and the public statewide.

New York City Poison Control Center is available 24 hours a day, 7 days a week and provides treatment advice about exposures to poisons or questions about medicine safety. Pharmacists and nurses certified in poison information are there to give advice, and all calls are free and confidential. Translator services are provided in more than 150 languages.

Upstate New York Poison Center is also available 24 hours a day, 7 days a week, and assists the medical community and general public with poison emergencies by providing state of the art management expertise. The center is involved in poison emergency telephone management, poison information resources, public education, professional education and research and data collection. Calls are answered by specialists in poison information, registered nurses and pharmacists trained in toxicology. Specialists provide the most efficient and up-to-date poison information available. Physicians and toxicologists are on-call 24 hours a day for consultation purposes. Other specialists are available for consultation.

Budget and HSI Claiming Details

Each center receives a share of the \$3 million annual grant. The grant is supported by a \$3 million appropriation, found on lines 21 through 25 of page 461 in the SFY 2015-16 Enacted Budget for Aid to Localities. The funding source is a HCRA Resources Fund, which is a State special revenue fund. In both SFY 2014-15 and 2015-16, New York City Regional Poison Control Center received \$1,851,130 and Upstate Poison Control Center received \$1,148,870.

The amount of funding related to services for children is determined by the percentage of calls that pertain to children (aged birth through 18), multiplied by the total amount of funding the center received. Upstate Poison Control Center received 55,778 calls in SFY 2014-15 and 28,351, or approximately 50.8%, were related to children (aged birth through 18).

Based on the call data, the amount of funds used for children-related activity in SFY 2015-16 can be calculated at approximately \$583,626 (\$1,148,870 x 50.8%). NYC Regional Poison Control Center received 91,824 calls in calendar year 2014 and 32,436, or approximately 35.3%, were related to children (aged birth through 18). Accordingly, the amount of funds used for children-related activity in SFY 2015-16 can be calculated at approximately \$653,449 (\$1,851,130 x 35.3%).

In total, approximately \$1,237,075 will fund children-related activity at the two poison control centers in SFY 2015-16 (\$583,626 + \$653,449). This annual amount (\$1,237,075) will be used prospectively to approximate the total funding for children-related activity.

DOH will perform periodic general ledger journal entries to transfer the qualified Poison Control Center expenditures to CHIP federal funding. These transactions will be performed in SFS and must be approved within DOH, and at OSC. Backup documentation will be included when processing these entries. There is a unique program code in SFS for the Poison Control Centers program and CHIP, as well as a program code within CHIP dedicated to the HSI.

Upon SPA approval, a general ledger journal entry or entries will be processed to charge CHIP for HSI-related expenditures made during SFY 2015-16. The federal matching rate of 65% will be used for expenditures made from April 1, 2015 to September 30, 2015, and the federal matching rate of 88% will be used for expenditures effective October 1, 2015. Prospectively, periodic journal entries will be processed to transfer HSI-related expenditures to CHIP federal funding.

5. Sickle-Cell Screening

Program Details

The Sickle Cell Screening program provides transition services for adolescents and young adults with sickle cell disease and other hemoglobinopathies. The goal is to ensure that adolescents and young adults with sickle cell disease and other hemoglobinopathies are able to transition from pediatric health care and parent-directed control of their health to adult care and self-directed control of their health. There are four New York City hospitals currently receiving awards: Bronx Lebanon Hospital Center, Brookdale University Hospital, NYC HHC – Harlem Hospital, and New York Methodist Hospital.

Contractors are required to include both a pediatric and adult hematologist in the program, paid by the contracting institution. They must also employ a transition navigator (who may be paid on the grant) who works with the adolescent and young adult patients, their families, their schools and/or employers and the clinic/hospital to successfully transition from parental care to self-care and from pediatric to adult oriented medicine.

Budget and HSI Claiming Details

The funding source for the sickle cell screening program is General Fund – Local Assistance. The General Fund is the State’s main operating fund. The appropriation is found on lines 30 and 31 of page 514 in the SFY 2015-16 Enacted Budget for Aid to Localities, and totals \$213,400.

The program handles individuals aged birth through 18 as well as some over age 18, but not over 21. The original applications for the program requested a breakdown of the numbers of patients of specific age groups. The applications indicated that 630 of the 828 individuals served, or approximately 76.1%, were aged birth through 18. Therefore, for the purpose of the SPA, it is projected that 76.1% of total spending is for services related to children. This percentage will be used prospectively and will be multiplied by the total expenditures for a period in order to calculate the level of expenditures for services related to children.

DOH will perform periodic general ledger journal entries to transfer eligible Sickle Cell costs to CHIP federal funding. These transactions will be performed in SFS and must be approved within DOH, and at OSC. Backup documentation will be included when processing these entries. There is a unique program code in SFS for the Sickle Cell program and CHIP, as well as a program code within CHIP dedicated to the HSI.

Upon SPA approval, a general ledger journal entry or entries will be processed to charge CHIP for HSI-related expenditures made during SFY 2015-16. The federal matching rate of 65% will be used for expenditures made from April 1, 2015 to September 30, 2015, and the federal matching rate of 88% will be used for expenditures effective October 1, 2015. Prospectively, periodic journal entries will be processed to transfer HSI-related expenditures to CHIP federal funding.

Assurances

New York assures that the two proposed HSI programs described above will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds.

New York also assures that all (100 percent) of the funds transferred (state and federal) are retained by the two Poison Control Centers and the Sickle-Cell Screening program.

2.3-TC

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

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

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

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

- 3.1.** Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

Under the CHPlus program, the Department contracts with health plans for the purchase of a managed care insurance product. Health plans are paid a per member per month (PMPM) fee for a uniform benefit package that is comparable to the Medicaid managed care package. Costs for vaccines are excluded from the PMPM fee and are purchased by the New York State Department of Health and distributed, for CHPlus enrollees, by the New York State and New York City Departments of Health through their Vaccine for Children programs. [and distributed, for CHPlus enrollees, by the NY State Department of Health through its Vaccine for Children program.] Children, through the managed care arrangement, have primary care providers who coordinate their health care, including referrals to specialists, when appropriate. Insurers participate in the program as a result of a competitive RFP process. However, those health plans that are approved New York State Medicaid Managed Care insurers are allowed to participate in the CHPlus program without a competitive bid or request for proposal process. These insurers are authorized to contract with the State to provide a CHPlus managed care product. Health plans are in every geographic region of the State, assuring statewide coverage. Health plans are monitored for the provision of health care services through the semi and annual reporting of the services provided and through the reporting of data through the quality assurance and reporting system.

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

The benefit package under the CHPlus program is a uniform benefit package that must be provided by all health plans. Plans cannot provide additional services outside of this benefit package. Since CHPlus is a managed care product and each child has a primary care physician, children receive health care that is appropriate, medically necessary, and/or approved by the State or the participating health plan.

Health plans participating in the CHPlus program, must have in place utilization review policies and procedures that include protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims meeting pre-defined criteria. Plans also must develop and implement procedures for identifying and correcting patterns of over and under utilization on the part of their enrollees.

More information can be found on utilization control in Section 7 - Quality and Appropriateness of Care.

Section 4. Eligibility Standards and Methodology

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. **Medicaid Expansion**

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

Children ages 6-18 from 100 to 133 percent of the Federal Poverty Level

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

4.1.0 Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

In accordance with Section 211 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), New York State enacted legislation effective October 1, 2010 adding a new eligibility requirement that children applying for Child Health Plus coverage who declare to be a United States citizen produce satisfactory documentary evidence of their citizenship status and identity. New York State has implemented the data file match process afforded under CHIPRA to comply with this requirement. Applying children who do not provide their Social Security Number and those children whose citizenship cannot be successfully verified by the Social Security Administration must supply documentation of United States citizenship and identity.

4.1.1 Geographic area served by the Plan if less than Statewide:

4.1.2 Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

4.1.2.1-PC Age: Less than 19 years of age under 400 percent of the federal poverty level.

4.1.3 Income of each separate eligibility group (if applicable):

4.1.3.1-PC 0% of the FPL (and not eligible for Medicaid) through 400% of the FPL (SHO #02-004, issued November 12, 2002)

Effective September 1, 2008, a child residing in a household having a gross household income at or below 400 percent of the federal poverty level (as defined and annually revised by the federal Office of Management and Budget) is eligible for Child Health Plus.

4.1.4 Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

4.1.5 Residency (so long as residency requirement is not based on length of time in state):

A child must be a resident of New York State.

4.1.6 Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7 Access to or coverage under other health coverage:

Child must not be eligible for Medicaid, have other insurance coverage unless the policy is one of the “Excepted Benefits” set forth in federal Public Health Service Act (accident only coverage or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including auto insurance; worker’s compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; dental only, vision only, or long term care insurance; specified disease coverage; hospital indemnity or other fixed dollar indemnity coverage; or CHAMPUS/Tricare supplemental coverage) or have a parent or guardian who is a public employee of the State or public agency with access to family health insurance coverage by a state health benefits plan where the public agency pays all or part of the cost of the family health insurance coverage.

4.1.8 Duration of eligibility, not to exceed 12 months:

The period of eligibility shall commence on the first day of the month during which a child is determined eligible, as described below, an end on the last day of the twelfth month of coverage. The period of eligibility shall cease if the child no longer resides in New York State; has access to the New York State Health Insurance Program or has obtained other health insurance coverage; has become enrolled in Medicaid; has reached the age of 19; or the applicable premium payment has not been paid. At the State's discretion, either allow additional time for enrollees to pay outstanding family premium contributions or waive such contributions for enrollees living in and/or working in FEMA or Governor declared disaster areas at the time of the disaster event. In the event of a disaster, the State will notify CMS of the intent to provide temporary adjustments to its enrollment and/or re-determination policies, the effective dates of such adjustments and the counties/areas impacted by the disaster.

Effective January 1, 2014, children whose application is submitted to New York State of Health (NY State of Health), New York's Health Insurance Marketplace, by the 15th of the month, shall be enrolled on the first day of the next month if determined eligible. Applications received by NY State of Health after the 15th day of the month will be processed for the first day of the second subsequent month. In no case is a child enrolled more than 45 days after submission of the application. Implemented on October 2017, if a child renews their coverage after the 15th day of the month but before the last day of the month of their 12-month enrollment period and the child selects the same health plan, the child will remain continuously enrolled effective the first day of the subsequent month. If the child renews coverage after the last day of the month of coverage, the timeframes described above apply.

Effective January 1, 2017, a newborn who applies for coverage, is found eligible for the Child Health Plus program and selects a health plan within 60 days of the child's date of birth, will be given eligibility retroactive to the first day of the month of the child's date of birth. The family is provided with the option to choose the enrollment start date which can be either retroactive to the first of the month of the date of birth, the first of the month after the date of birth or prospective based on the 15th day of the month rule described above.

Implemented on August 1, 2017, children who originally enrolled directly with a health plan prior to January 1, 2014 will be transitioned to NY State of Health, New York's Health Insurance Marketplace, at their annual renewal. Children will receive a notice approximately 60 days prior to their renewal

with instructions regarding how they must renew their coverage on the Marketplace. If the child appears Medicaid eligible at renewal, the child will be enrolled in Medicaid through NY State of Health. The process to transition children originally enrolled with a health a health plan to NY State of Health was completed on July 31, 2018.

Families are required to report changes in New York State residency or health insurance coverage that would make a child ineligible for subsidy payments. Effective January 1, 2014, these changes must be provided to New York State of Health if that is where enrollment originated. If enrollment originated with the health plan prior to January 1, 2014 and the child's enrollment was not yet transitioned to NY State of Health, changes must be reported directly to the health plan. If a family submits required eligibility information that affects their enrollment status, the information will be implemented prospectively. A family may incur a different family premium contribution or enrolled in Medicaid based on the new information.

- 4.1.9 Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

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

New York requires that an applicant provide their social security number if they have one. Applicants who are unable to obtain a social security number due to their immigration status or because of religious objections may still apply for and be eligible for coverage.

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

- 4.1.9.2 Continuous eligibility

Fully eligible children are granted twelve months of continuous eligibility with the following exceptions: the child no longer resides in New York State; the child has access to the New York State Health Insurance

Program or has obtained other health insurance coverage; the child has enrolled in Medicaid; the child has reached the age of 19; or the applicable premium payment has not been paid. At the State’s discretion, either allow additional time for enrollees to pay outstanding family premium contributions or waive such contributions for enrollees living in and/or working in FEMA or Governor declared disaster areas at the time of the disaster event. In the event of a disaster, the State will notify CMS of the intent to provide temporary adjustments to its enrollment and/or re-determination policies, the effective dates of such adjustments and the counties/areas impacted by the disaster.

6. 1-PW **Pregnant Women Option** (section 2112) The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of “lawfully residing” children and/or pregnant women. States may elect to cover (1) “lawfully residing” children described at section 2107(e)(1)(J) of the Act; (2) “lawfully residing” pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

- 4.1- LR **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

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

- (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);

- (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) An alien who belongs to one of the following classes:
 - (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
 - (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
 - (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
 - (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101649, as amended;
 - (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
 - (vi) Aliens currently in deferred action status; or
 - (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
- (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
- (6) An alien who has been granted withholding of removal under the Convention Against Torture;
- (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));
- (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
- (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.



Elected for pregnant women.
 Elected for children under age 19.

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

4. 1-DS **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

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

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

4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. These standards do not deny eligibility based on a child having a preexisting medical condition. This applies to pregnant women as well as targeted low-income children.

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

4.2.1-DS These standards do not discriminate on the basis of diagnosis.

4.2.2-DS Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

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

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

Children must recertify annually. At the State’s discretion, additional time may be allowed for enrollees to complete the renewal process for enrollees living in and/or working in FEMA or Governor declared disaster areas at the time of the disaster event. In the event of a disaster, the State will notify CMS of the intent to provide temporary adjustments to its enrollment and/or redetermination policies, the effective dates of such adjustments and the counties/areas impacted by the disaster.

At State discretion, requirements related to timely processing of applications may be temporarily waived for CHIP applicants who reside and/or work in a State or Federal declared disaster area. At State discretion, requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests may be temporarily waived or extended for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area.

At State discretion, the state may provide for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the State or Federally declared disaster or public health emergency.

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.2.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102)(b)(2)) (42CFR, 457.305(b))

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

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

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

A two- month presumptive period of eligibility is available to children as a means of providing services under the Child Health Plus program when a child appears eligible for the program but pertinent documentation is missing. Effective January 1, 2014, if one or more pieces of required documentation such as income or immigration status is missing but the applicant appears eligible based on the application submitted to NY State of Health, the family is allowed up to two months to submit the documentation or the child is disenrolled from the program. At the State’s discretion, additional time may be allowed for enrollees to supply required documentation to fully enroll the child for enrollees living in and/or working in FEMA or Governor declared disaster areas at the time of the disaster event. In the event of a disaster, the State will notify CMS of the intent to provide temporary adjustments to its enrollment and/or redetermination policies, the effective dates of such adjustments and the counties/areas impacted by the disaster.

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3. 3-EL Express Lane Eligibility Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

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

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

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

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

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

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances.

(Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4. Eligibility screening and coordination with other health coverage programs

States must describe how they will assure that:

- 4.4.1. only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.

Effective January 1, 2014, New York State of Health application asks if the child has any other health insurance or Medicaid. If the child indicates he/she has other coverage, the application further asks for specific detail to determine if it is one of the excepted benefits as stated in 4.1.7. If it is not, the child is determined ineligible for Child Health Plus coverage. As a further check, prior to enrollment, a check is performed to ensure the child does not have Medicaid or other public coverage. If this results in a match, the child is not enrolled in Child Health Plus.

- 4.4.2. children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102(b)(3)(B)) (42CFR, 457.350(a)(2))

Effective January 1, 2014, New York State of Health, New York's Health Insurance Marketplace, is an integrated eligibility system that determines eligibility for Child Health Plus, Medicaid and Qualified Health Plans, with and without tax credits. The applicant applies for financial assistance, not a specific program. If, based on eligibility factors, the child is determined Medicaid eligible, he/she will be enrolled in Medicaid and not Child Health Plus.

Effective August 1, 2017, children who originally enrolled directly with a health plan prior to January 1, 2014 will be transitioned to NY State of Health, New York's Health Insurance Marketplace, at their annual renewal. Children will receive a notice approximately 60 days prior to their renewal with instructions regarding how they must renew their coverage on the Marketplace. If the child appears Medicaid eligible at renewal, the child will be enrolled in Medicaid through NY State of Health. All children whose enrollment originated with a health plan have transitioned to NY State of Health effective July 31, 2018.

- 4.4.3. children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

Effective January 1, 2014, New York State of Health, New York's Health Insurance Marketplace, is an integrated eligibility system that determines eligibility for Child Health Plus, Medicaid and Qualified Health Plans, with and without tax credits. The applicant applies for financial assistance, not a specific program. If, based on eligibility factors, the child is determined Child Health Plus eligible, he/she will be enrolled in Child Health Plus, not Medicaid.

- 4.4.4. the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)

The State monitors prior insurance of applicants to ensure that the program does not substitute for coverage under group health plans. The application

on New York State of Health asks if the applicant currently has insurance or if they have had coverage within the past 90 days. If they currently have health coverage, they are not eligible for the program. If they had health coverage, they are questioned if it was through their employer and the reason they no longer have health insurance through their employer. For children under 250 percent of the federal poverty level, the State collects the information on prior health insurance status quarterly from the health plans. This information is analyzed to determine the percentage of new enrollees who have dropped employer-based health insurance for enrollment in CHPlus. If the percentage reaches an average of eight (8) percent for the last three (3) quarters, a six-month waiting period will be imposed. The responsible adult filling out an application must attest to the source and nature of any health care coverage the child is receiving or has received in the past six months.

Children whose gross family income is between 251% and 400% of the federal poverty level (as defined and updated by the United States Department of Health and Human Services) cannot have had a private employer-based health insurance coverage during the past six months unless such coverage was dropped due to the following:

- (a) Loss of employment due to factors other than voluntary separation;
- (b) Death of the family member which results in termination of coverage under a group health plan under which the child is covered;
- (c) Change to a new employer that does not provide an option for comprehensive health benefits coverage;
- (d) Change of residence so that no employer-based comprehensive health benefits coverage is available;
- (e) Discontinuation of comprehensive health benefits coverage to all employees of the applicant's employer;
- (f) Expiration of the coverage periods established by COBRA or the provisions of subsection (m) of section three thousand two hundred twenty-one, subsection (k) of section four thousand three hundred four and subsection (e) of section four thousand three hundred five of the insurance law;
- (g) Termination of comprehensive health benefits coverage due to long term disability;
- (h) The cost of employment based health insurance is more than 5 percent of the family's income;
- (i) A child applying for coverage under these provisions is pregnant;

- (j) A child applying for coverage under this provision is at or below the age of five;
- (k) Child has special health care needs;
- (l) Child lost coverage as a result of a divorce; or
- (m) The cost of family coverage including the child exceeds 9.5% of household income.

The Department will monitor the number of children who are subject to the waiting period.

4.4.4.1. (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))

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

Through statewide CHPlus and Medicaid coverage, the provision of health insurance to targeted low-income children in the State who are Indians as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c) is ensured. The Department also maintains an Indian Health Program which deals directly with the Native American populations on or near all reservations in the State. All health care providers who deal with the Native American population encourage enrollment in CHPlus. The referral process to CHPlus is included in the contracts between the Department and reservation health care providers.

To further enhance outreach and potential enrollment of Native Americans, several IPA/Navigator grantees provide application assistance to tribes throughout the State.

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL

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

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

The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

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

Section 5 Outreach (Section 2102(c))

Describe the procedures used by the State to accomplish:

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

The Connections to Coverage Campaign, the Department's multi-faceted outreach campaign, is used to identify and assist in enrolling uninsured children into the Child Health Plus and Medicaid programs. Campaign strategies include developing community partnerships, conducting outreach at community events, training community partners about public health insurance and raising public awareness of the programs through distribution of health education materials.

In 2009-2010, outreach staff expanded their work with community-based human service organizations serving children and their families, through work with schools, emergency food providers and local government. Partnering with community-based organizations has proven to be a successful strategy for outreaching families of uninsured children. Community partners identify uninsured children and parents served by their programs and link them to facilitated enrollers who provide application assistance. Outreach staff tailors enrollment strategies after assessing the demographics of a community and the capacity of an organization. Providing more targeted, local outreach efforts are more effective as we continue to try to enroll the more hard-to-reach populations.

Additionally, CHPlus health plans are responsible for marketing the CHPlus program in their service areas. All approved health plans must develop a comprehensive plan of all marketing and enrollment activities they will engage in during the year. The plan must be submitted to the Department for review and approval prior to implementation. Any subsequent change or additions to a health plan's marketing plan must be submitted to the Department at least thirty (30) days prior to implementation and must be approved by Department prior to implementation of such plan or change. Health plans may distribute marketing material in local community centers and gathering places, markets, pharmacies, hospitals, schools, health fairs and other areas where potential beneficiaries are likely to gather. Door-to-door distribution of material is not permitted. Health plans may not offer incentives of any kind to CHPlus recipients to join a health plan.

Incentives are defined as any type of inducement, either monetary or in-kind which might reasonably be expected to result in the person receiving it to join a health plan. However, health plans may offer nominal gifts of not more than five dollars (\$5.00) in value as part of a health fair or other promotional activity to stimulate interest in the CHPlus program. These nominal gifts must be given to everyone who requests them regardless of whether or not they intend to enroll in the health plan.

Model Application Template for the State Children's Health Insurance Program

New York established a facilitated enrollment program in 1999 to assist families in applying for public health insurance programs. We contract with 41 community-based organizations including child advocacy groups, health care providers, rural health networks, perinatal networks and local governments to provide facilitated enrollment for CHPlus and Medicaid. These organizations provide application assistance in community-based settings. Approximately \$17 million was awarded to these organizations during the period April 1, 2010 through March 31, 2011 to support locally-tailored programs to develop and implement the necessary enrollment infrastructure. The facilitated enrollment program was re-procured in 2011 for contracts effective January 1, 2012. Approximately \$15.3 million was awarded to 41 community-based organizations throughout the State.

Facilitated enrollers provide families with eligibility information, assist them in completing the application, help gather documentation and submit the application to the health plan of the family's choice for enrollment in CHPlus or the local social services district for enrollment in Medicaid. Facilitated enrollers are available during evening and weekend hours, making enrollment more convenient for working families. By removing some of the identified barriers to enrollment, the Department, through the facilitated enrollers, can ensure that each child enters the system and receives services through the "right door", without families having to search for that door. In doing so, the Department has created a system that balances and coordinates federal and state statutes with the goal of enrolling targeted low-income children.

Section 6. Coverage Requirements for Children’s Health Insurance

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c))

6.1.1.3. HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- The coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
 - dental services
 - inpatient and outpatient hospital services,
 - physicians' services,
 - surgical and medical services,
 - laboratory and x-ray services,
 - well-baby and well-child care, including age-appropriate immunizations, and
 - emergency services;
- The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- The coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
 - coverage of prescription drugs,
 - mental health services,
 - vision services and
 - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan

that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

- 6.1.2.** Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If “existing comprehensive state-based coverage” is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for “existing comprehensive state-based coverage” must be described in the space provided for all states. (Section 2103(a)(3))

- 6.1.3** Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

- 6.1.4.** Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

- 6.1.4.1.** Coverage the same as Medicaid State plan
- 6.1.4.2.** Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver
- 6.1.4.3.** Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in · 457.420
State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

- 6.1.4.4.** Coverage that includes benchmark coverage plus additional coverage

- 6.1.4.5** Coverage that is the same as defined by existing comprehensive state-

based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. Other (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

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

6.2.1. Inpatient services (Section 2110(a)(1))

- **Inpatient Hospital Medical or Surgical Care**

Scope of Coverage: Inpatient hospital medical or surgical care will be considered a covered benefit for a registered bed patient for treatment of an illness, injury or condition which cannot be treated on an

outpatient basis. The hospital must be a short-term, acute care facility and New York State licensed.

Level of Coverage: Includes 365 days per year coverage for inpatient hospital services and services provided by physicians and other professional personnel for covered inpatient services; bed and board, including special diet and nutritional therapy; general, special and critical care nursing service, but not private duty nursing services; facilities, services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care; oxygen and other inhalation therapeutic services and supplies; drugs and medications that are not experimental; sera, biologicals, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies; blood products, except when participation in a volunteer blood replacement program is available to the insured or covered person, and services and equipment related to their administration; facilities, services, supplies and equipment related to physical medicine and occupational therapy and rehabilitation; facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electro-encephalographic studies and examinations; facilities, services, supplies and equipment related to radiation and nuclear therapy; facilities, services, supplies and equipment related to emergency medical care; chemotherapy; any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the hospital. No benefits will be provided for any out-of-hospital days, or if inpatient care was not necessary; no benefits are provided after discharge; benefits are paid in full for accommodations in a semi-private room.

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

- **Professional Services for Diagnosis and Treatment of Illness and Injury**

Scope of Coverage: Provides services on ambulatory basis by a covered provider for medically necessary diagnosis and treatment of sickness and injury and other conditions including the screening, diagnosis and treatment of autism spectrum disorders. An Autism spectrum disorder means any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders, including autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder or pervasive developmental disorder not otherwise specified. All services related to outpatient visits are covered, including physician

services.

Level of Coverage: No limitations. Includes wound dressing and casts to immobilize fractures for the immediate treatment of the medical condition. Injections and medications provided at the time of the office visit or therapy will be covered. Includes audiometric testing where deemed medically necessary.

- **Outpatient Surgery**

Scope of Coverage: Procedures performed within the provider's office will be covered as well as "ambulatory surgery procedures" which may be performed in a hospital-based ambulatory surgery service or a freestanding ambulatory surgery center.

Level of Coverage: The utilization review process will ensure that the ambulatory surgery is appropriately provided.

- **Emergency Medical Services**

Scope of Coverage: For services to treat an emergency condition in hospital facilities. For the purpose of this provision, "emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (B) serious impairment to such person's bodily functions; (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.

Level of Coverage: No limitations.

6.2.3. ☒ Physician services (Section 2110(a)(3))

- **Pediatric Health Promotion visits.**

Scope of Coverage: Well child care visits in accordance with a visitation schedule established by American Academy of Pediatrics and the Childhood Immunization Schedule of the United States will be followed for immunizations.

Level of Coverage: Includes all services related to visits. Includes immunizations, well child care, health education, tuberculin tests

(Mantoux), hearing tests, dental and developmental screening, clinical laboratory and radiological tests, eye screening, and lead screening.

- **Professional Services for Diagnosis and Treatment of Illness and Injury**

See Section 6.2.2.

- **Professional Services for Diagnosis and Treatment of Illness and Injury**

See Section 6.2.2.

6.2.4. ☒ Surgical services (Section 2110(a)(4))

- **Please refer to Section 6.2.1. Inpatient Services; Section 6.2.2. Outpatient Services; and Section 6.2.28 Maternity Services**

- **Pre-surgical testing**

Scope of Coverage: All tests, (laboratory, x-ray, etc) necessary prior to inpatient or outpatient surgery.

Level of Coverage: Benefits are available if a physician orders the tests; proper diagnosis and treatment require the tests; and the surgery takes place within 7 days after the testing. If surgery is cancelled because of pre-surgical test findings or as a result of a second opinion on surgery, the cost of the tests will be covered.

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

See Section 6.2.2 In accordance with section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), federally-qualified health centers and rural health clinics (further referred to as FQHCs) will be reimbursed using an alternative payment methodology for all services provided on or after October 1, 2009.

The Department will be calculating monthly supplemental payments utilizing the Medicaid prospective payment system (PPS) rates of payment to FQHCs and information provided by the FQHC. Supplemental payments to the FQHC will be made to the FQHC

through the participating CHPlus managed care organizations (MCO). Supplemental payments will be made for only claims paid and/or approved by the MCOs and/or their subcontracted Independent Practice Associations (IPAs).

In order to qualify for and receive supplemental payments for services provided to CHPlus enrollees, each FQHC must have approved PPS rates in effect for the time period and site where services were provided to a MCO enrollee; have an executed contract with the MCO, or an IPA that contracts with the MCO, for the time period; and must have received, in the aggregate, MCO payments for services rendered that are less than the FQHC would have received for those same services under the appropriate PPS Medicaid rates.

FQHCs are required to bill MCOs for all encounters for which a supplemental payment is being requested. MCOs will make payments on those claims based on their current contract or approve those claims in cases where a capitated arrangement exists between both parties. This information must be maintained and reported to the Department to ensure that the State is only making payment for an approved service that was properly billed.

Based on the information reported to the Department from the FQHC, the Department will calculate the supplemental payment that is due to each FQHC for each MCO. This “supplemental payment” is the aggregate difference between what that FQHC is paid through contracts with MCOs and its specific Medicaid PPS rate accumulated for each month.

The total supplemental payments due to FQHCs will be added to the appropriate MCO’s monthly voucher for their CHPlus enrollees. The MCO will pay the FQHC the supplemental payment no later than the end of the month they receive payment on their voucher.

The Department will compare information received from the FQHCs to the encounter data submitted by the MCOs, reconcile any material differences and adjust the supplemental payments accordingly.

The Department plans to implement an initiative to incentivize the development of patient-centered medical homes for the CHPlus program. The medical home initiative is based upon the standards developed by the National Committee for Quality Assurance’s (NCQA) for the Physician Practice Connections – Patient-Centered Medical Home Program (PPC-PCMH). The PPC-PCMH is a model of care that seeks to strengthen the physician-patient relationship by promoting improved access, coordinated care, and enhanced patient/family engagement. Office-based practitioners (physicians and

registered nurse practitioners) and Article 28 clinics that are approved as a medical homes and recognized by the NCQA as meeting the requirements of the PPC-PCMH program, will receive an additional payment for primary care services provided to CHPlus enrollees. Additionally, a subset of providers classified as medical homes came together to establish the Adirondack Medical Home Multipayer Demonstration Program. This Program was established to improve health care outcomes and efficiency through patient continuity and coordination of services. They will receive an additional payment for providing primary care services that differs from the medical home initiative describe above. The additional payment will be included in the per-member per-month all-inclusive premium paid to each MCO. The MCO is responsible for reimbursing the medical home. This initiative is expected to begin on October 1, 2011.

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))

Scope of Coverage: Prescription medications must be authorized by a professional licensed to write prescriptions.

Level of Coverage: Prescriptions must be medically necessary. May be limited to generic medications where medically acceptable. Includes family planning or contraceptive medications or devices. All medications used for preventive and therapeutic purposes will be covered, including prescription drugs needed to treat an autism spectrum disorder. Vitamin coverage need not be mandated except when necessary to treat a diagnosed illness or condition.

6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))

Scope of Coverage: Non-prescription medications authorized by a professional licensed to write prescriptions.

Level of Coverage: All medications used for preventive and therapeutic purposes authorized by a professional licensed to write prescriptions will be covered.

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))

- **Diagnostic and Laboratory Tests**

Scope of Coverage: Prescribed ambulatory clinical laboratory tests and diagnostic x-rays.

Level of Coverage: No limitations.

6.2.9.☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

- **Family Planning or Contraceptive Medications or Devices**

Scope of Coverage: Prescription medications must be authorized by a professional licensed to write prescriptions.

Level of Coverage: Prescriptions must be medically necessary. May be limited to generic medications where medically acceptable.

- **Prenatal Care**

See Section 6.2.28.

6.2.10.☒ **Inpatient mental health services**, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

Scope of coverage: Services provided in a facility operated by the Office of Mental Health under Section 7.17 of the Mental Hygiene Law, or a facility issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law or a general hospital as defined in Article 28 of the Public Health Law.

Level of coverage: No limitations.

6.2.11.☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))

- **Outpatient visits for mental health**

Scope of Coverage: Services must be provided by certified and/or licensed professionals.

Level of Coverage: No limitations, includes psychiatric and psychological care for treatment of an autism spectrum disorder.

6.2.12.☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

- **Durable Medical Equipment (DME)**

Scope of Coverage: All DME must be medically necessary and ordered by a plan physician.

Level of Coverage: DME not limited except there is no coverage for cranial prostheses (i.e. wigs) and dental prostheses, except those made necessary due to accidental injury to sound, natural teeth and provided within twelve months of the accident, and except for dental prostheses needed in treatment of a congenital abnormality or as part of reconstructive surgery. 2110(a)(13))

Includes coverage of assistive communication devices for children with autism spectrum disorder, who are unable to communicate through normal means such as speech or in writing, for coverage of dedicated communication devices such as communication boards and speech-generating devices which are purchased or rented. Health plans are not responsible for covering items such as laptops, desktops, or tablet computers but are responsible for covering software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device.

6.2.13. ☒ Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

- **Diabetic Supplies and equipment 2110(a)(13))**

Scope of Coverage: Insulin, blood glucose monitors, blood glucose monitors for legally blind, data management systems, test strips for monitors and visual reading, urine test strips, insulin injection aids, cartridges for legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, oral agents.

Level of Coverage: As prescribed by a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law.

- **Ostomy Supplies and equipment**

Scope of Coverage: Supplies and equipment used to contain diverted urine or fecal contents outside the body from a surgically created opening (stoma).

Level of Coverage: As prescribed by a health care provider legally authorized to prescribe under Title 8 of the Education Law.

6.2.14. ☒ Home and community-based health care services (Section 2110(a)(14))

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

- **Home Health Care Services**

Scope of Coverage: The care and treatment of a covered person who is under the care of a physician but only if hospitalization or confinement in a skilled nursing facility would have been otherwise required if home care was not provided, the service is approved in writing by such physician, and the plan covering the home health service is established by the Department.

Level of Coverage: Home care shall be provided by a certified home health agency possessing a valid certificate of approval issued pursuant to Article 36 of the Public Health Law. Home care shall consist of one or more of the following: part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.); part-time or intermittent home health aide services which consist primarily of caring for the patient; physical, occupational or speech therapy if provided by the home health agency; medical supplies, drugs and medications prescribed by a physician; and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered or provided if the covered person had been hospitalized or confined in a skilled nursing facility. A minimum of forty such visits must be provided in any calendar year.

- **Diabetic Education and Home Visits**

Scope of Coverage: Diabetes self-management education (including diet); reeducation or refresher. Home visits for diabetic monitoring and/or education.

Level of Coverage: Limited to medically necessary visits where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management or where reeducation is necessary. May be provided by a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered

dietitian upon the referral of a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law and shall be limited to group settings wherever practicable.

6.2.15. Nursing care services (Section 2110(a)(15))

6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))

Scope of Coverage: The federally funded portion of the CHPlus program will not be used to cover abortions except in the case of rape, incest or to save the life of the mother.

Level of Coverage: No limitations.

6.2.17. Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

Scope of Coverage: Emergency, preventive and routine dental services.

Level of Coverage: No limitations.

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

Scope of coverage: Services provided in a facility operated by the Office of Mental Health under Section 7.17 of the Mental Hygiene Law, or a facility issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law or a general hospital as defined in Article 28 of the Public Health Law.

Level of coverage: No limitations.

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

Scope of coverage: Services must be provided by certified and/or licensed professionals.

Level of coverage: No limitations.

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

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

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

- **Speech Therapy**

Scope of coverage: Speech therapies performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist.

Level of coverage: Those required for a condition amenable to significant clinical improvement within a two-month period, beginning with the first day of therapy. Covered speech therapy services for a child diagnosed with an autism spectrum disorder shall also be provided if deemed habilitative or non-restorative.

- **Hearing**

Scope of coverage: Hearing examinations to determine the need for corrective action.

Level of coverage: One hearing examination per calendar year is covered. If an auditory deficiency requires additional hearing exams and follow-up exams, these exams will be covered. Hearing aids, including batteries and repairs, are covered. If medically necessary, more than one hearing aid will be covered.

- **Physical and Occupational Therapy**

Scope of coverage: Short-term physical and occupational therapies.

Level of coverage: These therapies must be medically necessary and under the supervision or referral of a licensed physician. Short-term physical and occupational therapies will be covered when ordered by a physician. Physical and occupational therapies for a child diagnosed with an autism spectrum disorder are also covered when such treatment is deemed habilitative or nonrestorative.

6.2.23 ☒ Hospice care (Section 2110(a)(23))

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician;

or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

- **Hospice**

Scope of Coverage: Coordinated hospice program of home and inpatient services which provide non-curative medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six months or less.

Level of Coverage: Hospice services include palliative and supportive care provided to a patient to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement. In accordance with Section 2302 of the Affordable Care Act, children are allowed to receive hospice services without forgoing any medically necessary curative services included in the Child Health Plus benefit package. Hospice organizations must be certified under Article 40 of the NYS Public Health Law. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by federal and state requirements. All services must be provided according to a written plan of care which reflects the changing needs of the patient/family. Family members are eligible for up to five visits for bereavement counseling (bereavement counseling not funded through program).

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

- **Therapeutic Services**

Scope of Coverage: Ambulatory radiation therapy and chemotherapy. Injections and medications provided at time of therapy (i.e., chemotherapy) will also be covered. Hemodialysis will be a covered service. Short term physical and occupational therapies will be covered when ordered by a physician. Infusion of blood clotting factor and other services in connection with the treatment of blood clotting protein deficiencies.

Level of Coverage: No limitations. These therapies must be medically necessary and under the supervision or referral of a licensed physician. No experimental procedures or services will be reimbursed. Determination of the need for hemodialysis services and whether

home based or facility based treatment is appropriate will be made by a licensed physician. Coverage for blood clotting factor, supplies and other services needed for home infusion of blood clotting factor for the treatment of a blood clotting protein deficiency. Infusion may be performed in an outpatient setting or in the home by a home health care agency, a properly trained parent of legal guardian of a child or a properly trained child that is physically and developmentally capable of self-administering such products.

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

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

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

- **Non-Air-Borne, pre-hospital emergency medical services provided by an ambulance service.**

Scope of Coverage: Pre-hospital emergency medical services, including prompt evaluation and treatment of an emergency condition and/or non-airborne transportation to a hospital.

Level of Coverage: Services must be provided by an ambulance service issued a certificate to operate pursuant to section 3005 of the Public Health Law. Evaluation and treatment services must be for an emergency condition defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

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

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

- **Maternity Care**

Scope of Coverage: Inpatient hospital coverage for at least 48 hours after childbirth for any delivery other than a Caesarean section (C-Section) and at least 96 hours following a C-Section. Also coverage of parent education, assistance and training in breast or bottle feeding, and any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the 48/96 hours, provided that at least one home care visit is covered post-discharge. Prenatal, labor and delivery care is covered, including surgical services rendered as part of a C-section.

Level of Coverage: No limitations; (However children potentially eligible for Medicaid requiring maternity care services will be referred to Medicaid. Pregnant women up to 200% net FPL are eligible for Medicaid's PCAP program. This is a program expressly designed for pregnant women. This program allows for presumptive eligibility determined at the provider's care site. Enrollees are required to report any change of circumstances that affect eligibility. This information will be reviewed by the health plan and the enrollee is referred to PCAP if she appears eligible.).

Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan:

- **COVID-19 Vaccine:**

- The state provides coverage of COVID-19 vaccines and their administration, in accordance with the requirements of section 2103(c)(11)(A) of the Act.

- **COVID-19 Testing:**

- The state provides coverage of COVID-19 testing, in accordance with the requirements of section 2103(c)(11)(B) of the Act.
- The state assures that coverage of COVID-19 testing is consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.
- The state assures that coverage includes all types of FDA authorized COVID-19 tests.

- **COVID-19 Treatment:**
 - The state assures that the following coverage of treatments for COVID-19 are provided without amount, duration, or scope limitations, in accordance with requirements of section 2103(c)(11)(B) of the Act:
 - o The state provides coverage of treatments for COVID-19 including specialized equipment and therapies (including preventive therapies);
 - o The state provides coverage of any non-pharmacological item or service described in section 2110(a) of the Act, that is medically necessary for treatment of COVID-19; and
 - o The state provides coverage of any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations.

- **Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:**
 - The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without amount, duration, or scope limitations, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) of the Act.

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

- 6.2.1-DC** **State Specific Dental Benefit Package.** The State assures dental services represented by the following categories of common dental terminology (CDT¹) codes are included in the dental benefits:
1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
 2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
 3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
 4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
 5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
 6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
 7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
 8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
 9. Emergency Dental Services

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

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

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

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

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

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

6.2-DS **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description. In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

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

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

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

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

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

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

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

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

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the

requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42CFR, 457.1005(a))

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

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

Guidance: Check 6.4.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary’s satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective. The State’s cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage

under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

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

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

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

Yes
 No

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

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

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

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

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i),

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

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

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

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

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

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

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

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

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

Yes
 No

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

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

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

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

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

Section 7 *Quality and Appropriateness of Care*

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

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

Will the State utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. Quality standards

Health plans are responsible for ensuring that the services and providers under CHPlus meet the quality of care standards required in the Public Health Law and related regulations.

Health plans must have internal quality assurance programs and written quality improvement or assurance plans (Quality Improvement Programs/Quality Assurance Programs (QAP)) for monitoring and improving the quality of care furnished to members. Such plans must address all of the following:

- Description of quality assurance committee structure;
- Identification of departments/individuals responsible for QAP implementation;
- Description of manner in which network providers may participate in QAP;
- Credentialing/re-credentialing procedures;
- Standards of care;
- Standards of service accessibility;
- Medical records standards;
- Utilization review procedures;
- Quality indicator measures and clinical studies;
- Quality assurance plan documentation methods; and
- Description of the manner in which quality assurance/quality improvement activities are integrated with other management functions.

Also, health plans are required to institute a credentialing process for their providers that includes, at a minimum, obtaining and verifying the following information:

- Evidence of valid current license and valid DEA certificate, as applicable;
- Names of hospitals, health maintenance organizations (HMOs), prepaid health services plans (PHSPs), and medical groups with which the provider has been associated;
- Reasons for discontinuance of such associations;
- Level of malpractice coverage;

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- Pending professional misconduct proceedings or malpractice actions and the substance of such allegations;
- Substance of any findings from such proceedings;
- Sanctions imposed by Medicare or Medicaid;
- Names and relevant information of providers who shall serve as on-call designees for the provider (applies to non-staff, group models only).

Health plans must ensure that all on-call providers are in compliance with plan credentialing standards, including any non-participating providers serving in this capacity;

- Attention of provider as to validity of information provided;
- Information from other HMOs or hospitals with which provider has been associated regarding professional misconduct or medical malpractice, and associated judgments/settlements, and any reports of professional misconduct by a hospital;
- Review of provider's physical site of practice;
- Review of provider's capacity to provide such services, based on practice size and available resources; and
- Review of National Practitioner Data Bank profile

Health plans must re-credential their providers at least once every two years. During such re-credentialing, health plans should re-examine the items covered during the initial credentialing, as well as complaints lodged against the provider by plan members and results of chart audits and other quality reviews.

7.1.2. Performance measurement

As stated above in section 7.1, health plans are required to submit specific quality performance data on an annual basis which is consistent with the New York State Department of Health Quality Assurance Reporting Requirement (QARR). These data are used to compare health plan performance on an annual basis, both on an individual plan and statewide basis. The measures are a combination of measures from the National Committee for Quality Assurance (NCQA) Health Plan Employer Data Base Information Set (HEDIS) and child and adolescent care measures developed by the New York State Department of Health (NYSDOH). The measures change each year. Specific measures and performance can be examined in the New York State CHIP Annual Report.

Other information collected by the Department and used in the performance measurement includes the following:

Membership

- Member months of enrollment by age, sex and payer
- Enrollment by county

Utilization

- Frequency of selected conditions
- Inpatient care
- Ambulatory care

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- Disenrollment rate

Quality

- Prenatal care: low birth weight, entry in first trimester, initial prenatal care visit, number of prenatal care visits, stage of pregnancy at time of enrollment
- HIV education (age 12-18)
- Substance abuse counseling (age 12-18)
- Mental health follow-up

Access & Member Satisfaction

- Utilization of primary care providers by children
- Availability (waiting times for scheduled appointments)
- Uniform member satisfaction
- Provision of urgent and emergency medical care

General Health Plan Management

- Quality and service improvement studies
- Case management
- Utilization management
- Risk management
- Provider compensation
- New member orientation/education
- Language services
- Arrangements with public health, education and social services

7.1.3. Information strategies

Department sponsored quality assurance studies may be conducted during the contract period. The participating health plans in the Child Health Plus program have a contractual responsibility to work with the Department or its agent to complete the quality assurance study within the specified time frames. This includes supplying the medical records of enrolled children who are selected for the study sample and responding to inquires from the contractor.

7.1.4. Quality improvement strategies

Health plan performance based on the annual performance data submissions are compared to the statewide average as well as previous year's performance of the individual plan. Based on this information as well as information obtained from various other required reporting provided by the health plans, such as enrollee satisfaction surveys and provider network submissions, the Department identifies areas where improvement in plan performance is required or has occurred. When necessary, health plans are required to submit root cause analysis and improvement strategies that will be implemented by the plan to improve plan performance, especially in the areas of access to well child care and childhood and adolescent immunizations as detailed previously.

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

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

In order to assure access to primary and preventive health care, including well-child care, well-adolescent care and childhood and adolescent immunizations, health plans must establish and maintain provider networks with sufficient numbers of providers in geographically accessible locations for the populations they serve. Health plan networks must contain all of the provider types necessary to furnish the prepaid benefit package, including: well child care in accordance with visitation schedule established by American Academy of Pediatrics, immunizations according to the Immunization Schedule of the United States, hospitals, physicians (primary care and specialist), mental health and substance abuse providers, allied health professionals, pharmacies, and DME providers. Health plans shall not include in their networks, for purposes of serving CHPlus enrollees, any medical provider who has been sanctioned by Medicare or Medicaid if the provider has, as a result of the sanctions, been prohibited from serving Medicaid clients or receiving medical assistance payments.

Additionally, health plans must offer every member the opportunity to select from at least 3 primary care physicians within the following distance/travel time standards:

- Non-metropolitan areas – 30 miles/30 minutes
- Metropolitan areas – 30 minutes by public transportation

Transport time and distance in rural areas to primary care sites and hospitals may be greater than 30 minutes/30 miles only if based on the community standard for accessing care or if by beneficiary choice.

Quality of care delivered by health plans is monitored by the use of both external and internal monitoring methods. Health plans participating in the Child Health Plus program are required to submit specific quality performance data to the Department of Health which is consistent with the New York State Department of Health Quality Assurance Reporting Requirements (QARR) data specifications, on an annual basis for the CHPlus population. These data provide information on health plan performance with respect to primary and preventive health visits, access to health care, and medical management of select chronic diseases.

Specific child health measures are included annually in the data collection. These data include Use of Appropriate Medications for People with Asthma (Ages 5-17); and the percentage of children age 3 months to 18 years with a diagnosed upper respiratory infection and who were not given a prescription for an antibiotic, the percentage of children age 2–18 years with a diagnosis of Pharyngitis who were prescribed an antibiotic and were given a group A streptococcus test, and Annual Dental Visit.

Health plans must have internal quality assurance programs and written quality improvement or assurance plans (Quality Improvement Programs/Quality Assurance Programs (QAP)) for monitoring and improving the quality of care furnished to members. Such plans must address all of the following:

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- Description of quality assurance committee structure;
- Identification of departments/individuals responsible for QAP implementation;
- Description of manner in which network providers may participate in QAP;
- Credentialing/re-credentialing procedures;
- Standards of care;
- Standards of service accessibility;
- Medical records standards;
- Utilization review procedures;
- Quality indicator measures and clinical studies;
- Quality assurance plan documentation methods; and
- Description of the manner in which quality assurance/quality improvement activities are integrated with other management functions.

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

Emergency Services:

In order to insure that members have access to covered services, including emergency services, in addition to maintaining adequate networks, health plans are prohibited from requiring members to seek prior authorization for services in a medical or behavioral health emergency. Health plans must inform their members that access to emergency services is not restricted and that if the member experiences a medical or behavioral health emergency, he/she may obtain services from a non-plan physician or other qualified provider, without penalty. However, health plans may require members to notify the plan or their PCP within a specified time after receiving emergency care and may require members to obtain prior authorization for any follow-up care delivered pursuant to the emergency.

Twenty-Four (24) Hour Coverage:

Health plans must provide coverage to members, directly or through their Primary Care Providers (PCPs), twenty-four (24) hours a day and seven (7) days a week. Health plans must instruct their members on how to obtain services after business hours and on weekends.

Telephone Access:

Health plans may require their PCPs to have primary responsibility for serving as after hours "on-call" telephone resource to members with medical problems. If the PCP performs this function, he/she cannot be permitted to "sing-out" (i.e., automatically refer calls) to an emergency room.

Whether or not the health plan assigns primary responsibility for after hours telephone access to a PCP, it must have a twenty-four hour toll free telephone number for members to call which is answered by a live voice (answering machines are not acceptable).

The Department monitors access to services and the adequacy and appropriateness of provider networks several ways. To ensure the adequacy and availability of insurer provider networks, the Department requires all health plans to submit electronically, on a quarterly basis, the complete provider and service networks by county. These submissions are reviewed by the Department to monitor the adequacy of network in terms of provider composition including, but not limited to, the availability of specialty providers as well as primary care providers and office sites and hours of operation. If

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the Department determines that deficiencies exist in the provider network that could impact member access to care, health plans are required to submit a plan of corrective action to the Department.

Health plans are required to submit semi-annual and annual operation reports to the Department which are used to monitor the availability of and use of services by health plans and their members. Health plans are required to report utilization statistics, ancillary service utilization, cost of and expense of services. Utilization statistics include emergency room visits, primary care visits by age group, immunizations, inpatient and outpatient utilization, dental visits, laboratory and ancillary therapies.

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

Service Accessibility: The State considers service accessibility to be one of the key determinants of quality of care and overall member satisfaction. Accordingly, health plans will be expected to take all necessary measures to ensure compliance with the access standards. Health plans must allow access to out-of-network providers when the network is not adequate for the enrollee's medical condition. The State will actively monitor health plan performance in this area and will take prompt corrective action if problems are identified.

One way the State monitors health plan performance for treatment of children with chronic health conditions is through the Quality Assurance Reporting Requirements (QARR). Several childhood-specific measures are collected which are used to monitor the health plans effectiveness in providing care to these children including the use of appropriate medications for people with asthma and the lead testing measure. Individual health plan performance is then compared to the statewide average of all other health plans' performance.

Also, Child Health Plus members contact the Department for assistance if they are unable to resolve problems associated with access to health care services. The Department works with individual families and health plans, as necessary, to insure that appropriate services are made available. The frequency of the type and nature of complaints is maintained and monitored by the Department on a monthly basis.

Specific standards are in place to ensure reasonable and timely access to providers. These standards include but are not limited to the following:

Days to Appointment: Health plans must abide by the following appointment standards:

- Urgent medical or behavioral problems within 24 hours;
- Non-urgent "sick visits" within 48 to 72 hours, as clinically indicated;
- Routine, non-urgent or preventive care visits within four weeks; and
- In-plan, non-urgent mental health or substance abuse visits within two weeks.

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

Health plans must develop and have in place utilization review policies and procedures that include protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims meeting pre-defined criteria. Health plans must complete prior authorization of health services in accordance with the medical needs of the member and within 14 days after the receipt of a request for services. Health plans also must develop procedures for identifying and correcting patterns of over- and under-utilization on the part of their enrollees.

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

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

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42 CFR 457.505)

8.1.1. YES

8.1.2. NO, skip to question 8.8.

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

8.2.1. Premiums:

Income	Individual Contribution	Family Maximum
< 160% FPL	\$0	\$0
160% - 222%*	\$9	\$27
223%-250%*	\$15	\$45
251%-300%*	\$30	\$90
301%-350%*	\$45	\$135
351%-400%*	\$60	\$180

*American Indians/Native Americans exempt from Family contribution

At the State's discretion, non-payment of premiums may be temporarily forgiven/waived or families may be given additional time to pay their premiums for CHIP applicants and/or existing beneficiaries who reside and/or work in a State or federally declared disaster area

8.2.2. Deductibles:

There are no deductibles.

8.2.3. Coinsurance or copayments:

Coinsurance is not allowed and there are no co-payments.

8.2.4. Other: _____

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these

amounts and any differences based on income. (Section 2103(e)(1)(B))(42CFR 457.505(b))

The cost sharing information is disseminated to potential enrollees through an informational brochure, a toll-free information and enrollment number and through the enrollment process with the health plans and facilitated enrollers. This information is also explained in the application.

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

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

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

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

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

The Department has reviewed the cost sharing requirements for each family size and income level to ensure that in no instance will the cost sharing requirement exceed five percent of a family's annual income for the coverage period. There are no co-payments for the CHPlus program, therefore, aggregate cost sharing is based on the family contributions towards the health care premium and does not exceed five percent of a family's annual income.

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

The Access NY application has a question which identifies children who are American Indians or Alaskan Natives. Once the child is determined to be an American Indian or Alaskan Native through appropriate tribal documentation, their family contribution is waived and they are fully subsidized by the program if their income is below 400 percent of the non-farm federal poverty limit.

8.7. Please provide a description of the consequences for an enrollee or applicant

who does not pay a charge. (42CFR 457.570 and 457.505(c))

Enrollees are billed monthly, either 60 or 90 days in advance prior to their month of coverage. The family premium contribution is due 30 days in advance of the month of coverage. The State does not terminate enrollees who failed to pay their family premium contribution prior to the beginning of the month of coverage. Enrollees are given an additional 30 day grace period (the actual month of coverage) to pay their family premium contribution.

In cases where the family premium contribution has not been received 15 days prior to the start of the coverage month, the health plan must send a notice to the family explaining that coverage for the enrollee will be terminated for non-payment if the premium contribution is not received by the last day of the month of coverage. This notice also informs the family of the right to challenge the termination for non-payment of the premium.

Health plans must disenroll a child effective the last day of the month of coverage if they do not receive the premium contribution for a child by that day. At the State's discretion, either allow additional time for enrollees to pay outstanding family premium contributions or waive such contributions for enrollees living in/and or working in FEMA or Governor declared disaster areas at the time of the disaster event. In the event of a disaster, the State will notify CMS of the intent to provide temporary adjustments to its enrollment and/or redetermination policies, the effective dates of such adjustments and the counties/areas impacted by the disaster.

Enrollees have the opportunity to request a review of their income and to provide proof of a decrease in income that would make the child eligible for Medicaid or for a lower family contribution by the last day of the month of coverage. The health plan would redetermine program eligibility and family contribution based on the revised information. A child remains enrolled in CHPlus if a dispute regarding family contribution arises until such dispute is resolved.

At State discretion, families may temporarily be given additional time to pay their premiums or non-payment of premium may be temporarily forgiven/waived for existing CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area

There are no other charges associated with the program, and the family has the option of paying more than one month's family contribution at a time.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
- The disenrollment process affords the enrollee an opportunity to

show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b)). At the State's discretion, either allow additional time for enrollees to pay outstanding family premium contributions or waive such contributions for enrollees living in/and or working in FEMA or Governor declared disaster areas at the time of the disaster event. In the event of a disaster, the State will notify CMS of the intent to provide temporary adjustments to its enrollment and/or redetermination policies, the effective dates of such adjustments and the counties/areas impacted by the disaster.

- In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
- The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

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

- 8.8.1. No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2. No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5)) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3. No funds under this Title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this Title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))
- 8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105(c)(7)(B)) (42CFR 457.475)
- 8.8.6. No funds provided under this title will be used to pay for any

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abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

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Section 9 Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

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

The strategic objective for the CHPlus Program is to provide access to inpatient, outpatient, primary and preventive health care services to low income children by removing financial barriers and providing a medical home through a managed care product. The program has been successful in increasing enrollment. The same strategies that have worked, advertising and facilitated enrollment, will continue to be employed.

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

The following performance goals and measures will be utilized to measure the effectiveness of the CHPlus Program to meet this objective:

- **Performance Goal:** Increase the number of insured children in the State;
Performance Measure: Analysis of current population survey (CPS) data to ensure that the number of insured children in the State remains stable or increases through CHPlus and Medicaid enrollment, while both the number and percentage of uninsured children under age 19 below 250 percent of the poverty level continues to decrease.
- **Performance Goal:** Program is accessible to all qualified families with uninsured children having knowledge of program availability;
Performance Measure: Outreach is being conducted in all areas of the State and parent and health plan satisfaction are high. County specific enrollment is studied to target outreach activities. Hotline calls are tracked to monitor success of outreach.
- **Performance Goal:** Children have better health care status;
Performance Measure: Health care indicators are increasing and children are receiving required preventive health care services.

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

Health plans are responsible for submitting information to the Department regarding their enrollment. Reports can be generated from this information which include: monthly enrollment reports (detailing new and ongoing enrollment and disenrollment, quarterly disenrollment reports, and quarterly reports on applicants' prior health insurance status to assess the potential for crowd-out. In 1994 New York State implemented the Quality Assurance Reporting

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Requirements (QARR) as a tool to measure and manage the quality of care provided to New York residents. QARR is largely based on the measures published by the National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS) and has been collected for New York CHPlus health plans since 1998. The health plans report data from the previous year in June of the current year (i.e., data from calendar year 2005 was submitted in June 2006). This data includes quality, access, utilization and descriptive data collected from managed care plans licensed to operate in New York State. The measures are separated into four major categories: effectiveness of care; access and availability of care; uses of services; and health plan descriptive information. Additionally, health plans submit semi-annual and annual financial and utilization reports, annual progress reports (detailing marketing and enrollment outcomes), demographic characteristics of enrollees and utilization outcomes.

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

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

Use of appropriate medications for people with asthma (Ages 5-17); Percentage of children age 3 months to 18 years with a diagnosed upper respiratory infection and who were not given a prescription for an antibiotic; Percentage of children age 2-18 years with a diagnosis of pharyngitis were prescribed an antibiotic and were given a group A streptococcus test; Children's access to PCPs; Annual dental visit; Practitioner turnover; Enrollment by county; Frequency of myringotomy; Frequency of tonsillectomy; Inpatient utilization and ambulatory care; and Follow-up care for children prescribed ADHD medication.

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9.3.8. Performance measures for special targeted populations.

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

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

Annual Report. The State provides an annual report to the Secretary which assesses the operation of the State plan under this title in each fiscal year, including the progress made in reducing the number of uncovered low-income children. The State reports to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

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

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

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

9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. Section 1132 (relating to periods within which claims must be filed)

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

The CHPlus program continues to involve the public in the design and implementation of the program, and ensures ongoing public involvement. The Department involves advocates for children, including the Children's Defense Fund and Statewide Youth Advocacy groups, on advisory committees. The Department's Maternal and Child Health Program, as well as

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private sector advocacy groups, continue to be involved in the multi-disciplinary approach to the program design and implementation. The Department discusses issues and encourages feedback on any change made to the program in order to assure a smooth and timely implementation of the change. Additionally, the Department holds quarterly operational workgroup meetings with health plans, facilitated enrollers, children's advocacy groups, local districts and others to discuss how the program can continue to be improved.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42CFR 457.120(c))

Child Health Plus participates in the quarterly Centers for Medicare and Medicaid Services (CMS) conference call to New York State's federally recognized Native American tribes. These calls discuss Native American health related issues concerning New York State's Child Health Plus program, Medicaid Managed Care Program, Family Health Plus Program, Office of Medicaid Management (Medicaid Fee-for-Service) and Clinic Reimbursement as they affect the Native Americans in New York State.

There is a designated Native American Contact (NAC) from CMS who initiates the calls, in addition to developing the agenda from input from the Nations and prior discussions. The tribes are given program updates, current status or they bring up issues that the Nations would like to discuss or review.

New York State's federally recognized tribes that are invited to participate are: The Oneida Nation, Onondaga Nation, St. Regis Mohawk Tribe, Seneca Nation, Tuscarora Tribe, Tonawanda Band of Senecas and the Cayuga Nation.

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

Public notice was provided via two mechanisms. First, a public notice of the increased family premium contribution levels for households with income between 251 and 400 percent of the Federal Poverty Level was published in the NYS Register on May 20, 2009. Additionally, this modification in eligibility was discussed in the NYS Legislature, a body representing the constituents of New York State including the affected population.

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

- Planned use of funds, including:
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
 - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

CHIP FFY Budget		
STATE:	<u>CHPlus Only</u>	<u>MA Expansion</u>
Federal Fiscal Year	2012	
State's enhanced FMAP rate		
Benefit Costs		
Insurance payments		
Managed care	[\$810,900,000] <u>\$607,836,000</u>	<u>\$196,644,000</u>
<i>per member/per month rate</i>	<u>\$179</u>	<u>\$176</u>
Fee for Service		
Total Benefit Costs	[\$810,900,000] <u>\$607,836,000</u>	<u>\$196,644,000</u>
(Offsetting beneficiary cost sharing payments)	(\$31,600,000)	
Net Benefit Costs	[\$779,300,000] <u>\$607,836,000</u>	<u>\$196,644,000</u>
Administration Costs		
Personnel	\$2,132,000	
General administration	\$2,268,000	
Contractors/Brokers		
Claims Processing		
Outreach/marketing costs	\$5,285,000	
Other – Medicaid Expansion Admin		<u>\$1,400,000</u>
Total Administration Costs	<u>\$9,685,000</u>	<u>\$1,400,000</u>
10% Administrative Cap	\$86,588,889	
Federal Share	[\$512,840,000] <u>\$384,111,400</u>	<u>\$128,728,600</u>
State Share	[\$276,145,000] <u>\$206,829,600</u>	<u>\$69,315,400</u>
Total Costs of Approved SCHIP Plan	[\$788,985,000] <u>\$590,941,000</u>	<u>\$198,044,000</u>
The Source of State Share Funds:		

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Benefit Costs

Enrollment projections are based on current estimates of funds earmarked for the CHPlus program.

**New York Child Health Plus Program
Benefit Budget FY 2012**

Fiscal Year	Year End Enrollment	Average Per Member Per Month	Total Benefit Cost	Premium Offset	Net Benefit Cost
2012	378,700	\$179.00	\$810,900,000	(\$31,600,000)	\$779,300,000

The participating health plans are reimbursed on a per-member per-month all-inclusive premium for all operational and programmatic costs incurred under this program, except vaccine costs.

The total costs were developed assuming an average monthly premium applied to an estimated monthly enrollment.

Funds are to be distributed from the Health Care Initiatives Pool for the Child Health Plus program in the following amounts:

- (i.) \$207 million - 1/1/00-12/31/00
- (ii.) \$235 million - 1/1/01-12/31/01
- (iii.) \$324 million - 1/1/02-12/31/02
- (iv.) \$450 million - 1/1/03-12/31/03
- (v.) \$461 million - 1/1/04-12/31/04
- (vi.) \$153 million - 1/1/05-12/31/05
- (vii.) \$325.5 million - 1/1/06-12/31/06
- (viii.) \$428.6 million - 1/1/07-12/31/07
- (ix.) \$453.7 million - 1/1/08-12/31/08
- (x.) \$453.7 million - 1/1/09-12/31/09
- (xi.) \$453.7 million - 1/1/10-12/31/10
- (xii.) \$113.4 million - 1/1/11-3/31/11
- (xiii.) \$324.7 million - 4/1/11-3/31/12
- (xiv.) \$346.4 million - 4/1/12-3/31/13
- (xv.) \$376.7 million - 4/1/13-3/31/14

The budgetary impact of implementation of provisions to temporarily extend the renewal period, presumptive enrollment period, enrollment grace period at renewal and/or to allow additional time or waiver of the family premium contribution for enrollees living in FEMA or Governor declared disaster areas is dependent on the specific easements that are put in place for each disaster period. In the event of a disaster, the State will notify CMS of the intent to provide temporary adjustments to its enrollment and/or redetermination policies, the effective dates of such adjustments and the counties/areas impacted by the disaster.

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Section 10 Annual Reports and Evaluations (Section 2108)

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

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

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

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

Section 11 Program Integrity (Section 2101(a))

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

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

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX. (Section 2107(e)) (42CFR 457.935(b))

The items below were moved from section 9.8. (Previously items 9.8.6-9.8.9)

11.2.1. 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. Section 1124 (relating to disclosure of ownership and related information)

11.2.3. Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. Section 1128A (relating to civil monetary penalties)

11.2.5. Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. Section 1128E (relating to the national health care fraud and abuse data collection program)

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

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid Plan.

12.1. Eligibility and Enrollment Matters

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

Review of eligibility and enrollment matters is conducted by both the health plans who determined the original enrollment and the Department. This combined approach complies with the federal requirement of affording an individual both an internal and external review. Enrollees are given sufficient notice that their eligibility may be terminated if they do not take action with specific instructions on what they must do. All requests for review are first addressed by the health plan. If the enrollee is still not satisfied with the determination, the enrollee can request an external review be completed by the state. A child will not be disenrolled during this review period.

The State assures that in the review process, enrollees have the opportunity to fully participate in the review process; decisions are made in writing; and impartial reviews are conducted in a reasonable amount of time and consideration is given for the need for expedited review when there is an immediate need for health services.

12.2. Health Services Matters

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

The health plans issue a subscriber contract, to every enrollee, which delineates the enrollee's rights and responsibilities. This contract explains the review process for health services matters. This process allows for an internal review conducted by the health plan and an external review conducted by an appeal agent certified by the state. All reviews are conducted within the time frames stipulated in federal regulation and all decisions will be made in writing.

The State assures that enrollees receive timely written notice of any determinations that include the reasons for the determination, an explanation of applicable rights to review, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.

The State assures that enrollees have the opportunity for an independent, external review of a delay, denial, reduction, suspension, termination of health services or failure to approve health services in a timely manner. The independent review is available at the external appeals level.

The State assures that enrollees have the opportunity to represent themselves or have representatives in the process at the external appeals level.

The State assures that enrollees have the opportunity to timely review of their files and other applicable information relevant to the review of the decision. While this is assured at each level of review, members will be notified of the timeframes for the appeals process once an external appeal is filed.

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The State assures that enrollees have the opportunity to fully participate in the review process, whether the review is conducted in person or in writing.

The State assures that reviews, which are expedited due to an enrollee's medical condition, are completed within 72 hours of the receipt of the request.

The State assures that reviews, except for those expedited due to an enrollee's medical condition, will be completed within 90 calendar days of the date a request is made.

(a) 12.3. Premium Assistance Programs

If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the Group Health Plan at initial enrollment and at each redetermination of eligibility.

Not applicable.

APPENDIX I

NEW YORK STATE CHILD HEALTH PLUS BENEFITS PACKAGE

Child Health Plus Benefits Package

No Pre-Existing Condition Limitations Permitted
 No Co-payments or Deductibles
 May 2015

General Coverage	Scope of Coverage	Level of Coverage
Pediatric Health Promotion Visits	Well child care visits in accordance with visitation schedule established by American Academy of Pediatrics, and the Advisory Committee on Immunization Practices recommended immunization schedule.	Includes all services related to visits. Includes immunizations which must be provided within 90 days from publication in the Morbidity and Mortality Weekly Report, well child care, health education, tuberculin testing (mantoux), hearing testing, dental and developmental screening, clinical laboratory and radiological tests, eye screening, lead screening, and reproductive health services, with direct access to such reproductive health services.
Inpatient Hospital or Medical or Surgical Care	As a registered bed patient for treatment of an illness, injury or condition which cannot be treated on an outpatient basis. The hospital must be a short-term, acute care facility and New York State licensed.	No benefits will be provided for any out-of-hospital days, or if inpatient care was not necessary; no benefits are provided after discharge; benefits are paid in full for accommodations in a semi-private room. A private room will be covered if medically warranted. Includes 365 days per year coverage for inpatient hospital services and services provided by physicians and other professional personnel for covered inpatient services: bed and board, including special diet and nutritional therapy; general, special and critical care nursing services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care; oxygen and other inhalation therapeutic services and supplies; drugs and medications that are not experimental; sera, biologicals, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies; blood products, except when participation in a volunteer blood replacement program is available to the insured or covered person, and services and equipment related to their administration; facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electro-encephalographic studies and examinations; facilities, services, supplies and equipment related to radiation and nuclear therapy; facilities, services, supplies and equipment related to emergency medical care; chemotherapy; any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the hospital.
Inpatient Mental Health and Alcohol and Substance Abuse Services	Services to be provided in a facility operated by OMH under sec. 7.17 of the Mental Hygiene Law, or a facility issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law or a general hospital as defined in Article 28 of the Public Health Law.	No limitations for inpatient mental health services, inpatient detoxification and inpatient rehabilitation.

General Coverage	Scope of Coverage	Level of Coverage						
Inpatient Rehabilitation	Acute care services provided by an Article 28 General Hospital	Services supplies and equipment related to physical medicine and occupational therapy and short-term rehabilitation.						
Professional Services for Diagnosis and Treatment of Illness and Injury	Provides services on ambulatory basis by a covered provider for medically necessary diagnosis and treatment of sickness and injury and other conditions. Includes all services related to visits. Professional services are provided on outpatient basis and inpatient basis.	No limitations. Includes wound dressing and casts to immobilize fractures for the immediate treatment of the medical condition. Injections and medications provided at the time of the office visit or therapy will be covered. Includes audiometric testing where deemed medically necessary.						
Hospice Services and Expenses	Coordinated hospice program of home and inpatient services which provide non-curative medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six months or less.	Hospice services include palliative and supportive care provided to a patient to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement. Hospice organizations must be certified under Article 40 of the NYS Public Health Law. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by federal and state requirements. All services must be provided according to a written plan of care which reflects the changing needs of the patient/family. Family members are eligible for up to five visits for bereavement counseling.						
Outpatient Surgery	Procedure performed within the provider's office will be covered as well as "ambulatory surgery procedures" which may be performed in a hospital-based ambulatory surgery service or a freestanding ambulatory surgery center.	The utilization review process must ensure that the ambulatory surgery is appropriately provided.						
Diagnostic and Laboratory Tests	Prescribed ambulatory clinical laboratory tests and diagnostic x-rays.	No limitations.						
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	<p>Durable Medical Equipment means devices and equipment ordered by a practitioner for the treatment of a specific medical condition which:</p> <ul style="list-style-type: none"> ⇒ Can withstand repeated use for a protracted period of time; ⇒ Are primarily and customarily used for medical purposes; ⇒ Are generally not useful in the absence of illness or injury; and ⇒ Are usually not fitted, designed or fashioned for a particular person's use. <p>DME intended for use by one person may be custom-made or customized.</p>	<p>Includes hospital beds and accessories, oxygen and oxygen supplies, pressure pads, volume ventilators, therapeutic ventilators, nebulizers and other equipment for respiratory care, traction equipment, walkers, wheelchairs and accessories, commode chairs, toilet rails, apnea monitors, patient lifts, nutrition infusion pumps, ambulatory infusion pumps and other miscellaneous DME.</p> <p>DME coverage includes equipment servicing (labor and parts). Examples include, but are not limited to:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Fitted/Customized leg brace</td> <td style="width: 50%;">Not fitted/Customized cane</td> </tr> <tr> <td>Prosthetic arm</td> <td>Wheelchair</td> </tr> <tr> <td>Footplate</td> <td>Crutches</td> </tr> </table>	Fitted/Customized leg brace	Not fitted/Customized cane	Prosthetic arm	Wheelchair	Footplate	Crutches
Fitted/Customized leg brace	Not fitted/Customized cane							
Prosthetic arm	Wheelchair							
Footplate	Crutches							

General Coverage	Scope of Coverage	Level of Coverage
	Prosthetic Appliances are those appliances and devices ordered by a qualified practitioner which replace any missing part of the body.	Covered without limitation except that there is no coverage for cranial prosthesis (<i>i.e.</i> wigs) and dental prosthesis, except those made necessary due to accidental injury to sound, natural teeth and provided within twelve months of the accident, and except for dental prosthesis needed in treatment of congenital abnormality or as part of reconstructive surgery.
	Orthotic Devices are those devices which are used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.	No limitations on orthotic devices except that devices prescribed solely for use during sports are not covered.
Therapeutic Services	Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (<i>i.e.</i> chemotherapy) will also be covered.	No limitations. These therapies must be medically necessary and under the supervision or referral of a licensed physician. Short term physical and occupational therapies will be covered when ordered by a physician. Physical and occupational therapies for a child diagnosed with an autism spectrum disorder are also covered when such treatment is deemed habilitative or nonrestorative. No procedure or services considered experimental will be reimbursed.
	Hemodialysis	Determination of the need for services and whether home-based or facility-based treatment is appropriate.
	Infusion of blood clotting factor and other services in connection with the treatment of blood clotting protein deficiencies	Coverage for blood clotting factor, supplies and other services needed for home infusion of blood clotting factor for the treatment of a blood clotting protein deficiency. Infusion may be performed in an outpatient setting or in the home by a home health care agency, a properly trained parent or legal guardian of a child, or a properly trained child that is physically and developmentally capable of self-administering such products.
Speech and Hearing Services Including Hearing Aids	Hearing examinations to determine the need for corrective action and speech therapy performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist.	One hearing examination per calendar year is covered. If an auditory deficiency requires additional hearing exams and follow-up exams, these exams will be covered. Hearing aids, including batteries and repairs, are covered. If medically necessary, more than one hearing aid will be covered. Covered speech therapy services are those required for a condition amenable to significant clinical improvement within a two-month period, beginning with the first day of therapy. Covered speech therapy services for a child diagnosed with an autism spectrum disorder shall also be provided if deemed habilitative or nonrestorative.
Pre-Surgical Testing	All tests (laboratory, x-ray, etc.) necessary prior to inpatient or outpatient surgery.	Benefits are available if a physician orders the tests: proper diagnosis and treatment require the tests; and the surgery takes place within seven days after the testing. If surgery is canceled because of pre-surgical test findings or as a result of a Second Opinion on Surgery, the cost of the tests will be covered.
Second Surgical Opinion	Provided by a qualified physician.	No limitations.
Second Medical Opinion	Provided by an appropriate specialist, including one affiliated with a specialty care center.	A second medical opinion is available in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation of a course of treatment of cancer.

General Coverage	Scope of Coverage	Level of Coverage
Outpatient Visits for Mental Health and for the Diagnosis and Treatment of Alcoholism and Substance Abuse	Services must be provided by certified and/or licensed professionals.	No limitations. Visits may include family therapy for alcohol, drug and/or mental health as long as such therapy is directly related to the enrolled child's alcohol, drug and/or mental health treatment.
Home Health Care Services	The care and treatment of a covered person who is under the care of a physician but only if hospitalization or confinement in a skilled nursing facility would otherwise have been required if home care was not provided and the plan covering the home health service is established and provided in writing by such physician.	Home care shall be provided by a certified home health agency possessing a valid certificate of approval issued pursuant to Article 36 of the Public Health Law. Home care shall consist of one or more of the following: part-time or intermittent home health aide services which consist primarily of caring for the patient, physical, occupational, or speech therapy if provided by the home health agency and medical supplies, drugs and medications prescribed by a physician, and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered or provided under the contract if the covered person had been hospitalized or confined in a skilled nursing facility. The contract must provide 40 such visits in any calendar year, if such visits are medically necessary.
Prescription and Non-Prescription Drugs	Prescription and non-prescription medications must be authorized by a professional licensed to write prescriptions.	Prescriptions must be medically necessary. May be limited to generic medications where medically acceptable. Includes family planning or contraceptive medications or devices. All medications used for preventive and therapeutic purposes will be covered. Vitamins are not covered except when necessary to treat a diagnosed illness or condition. Coverage includes enteral formulas for home use for which a physician or other provider authorized to prescribe has issued a written order. Enteral formulas for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein. Coverage for such modified solid food products shall not exceed \$2500 per calendar year.

General Coverage	Scope of Coverage	Level of Coverage
Emergency Medical Services	<p>For services to treat an emergency condition in hospital facilities. For the purpose of this provision, "emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:</p> <ul style="list-style-type: none"> ⇒ Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; ⇒ Serious impairment to such person's bodily functions; ⇒ Serious dysfunction of any bodily organ or part of such person; or ⇒ Serious disfigurement of such person. 	<p>No limitations.</p>

General Coverage	Scope of Coverage	Level of Coverage
Ambulance Services	Pre-hospital emergency medical services, including prompt evaluation and treatment of an emergency condition and/or non-airborne transportation to a hospital.	<p>Services must be provided by an ambulance service issued a certificate to operate pursuant to Section 3005 of the Public Health Law.</p> <p>Evaluation and treatment services must be for an emergency condition defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:</p> <ul style="list-style-type: none"> ⇒ Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; ⇒ Serious impairment to such person's bodily functions; ⇒ Serious dysfunction of any bodily organ or part of such person; or ⇒ Serious disfigurement of such person. <p>Coverage for non-airborne emergency transportation is based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonable expect the absence of such transportation to result in:</p> <ul style="list-style-type: none"> ⇒ Placing the health of the person afflicted with such condition in serious jeopardy; ⇒ Serious impairment to such person's bodily functions; ⇒ Serious dysfunction of any bodily organ or part of such person; or ⇒ Serious disfigurement of such person.
Maternity Care	Inpatient hospital coverage for at least 48 hours after childbirth for any delivery other than a C-Section and in at least 96 hours following a C-section. Also coverage of parent education, assistance and training in breast and bottle feeding and any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the 48/96 hours, provided that at least one home care visit is covered post-discharge. Prenatal, labor and delivery is covered.	No limitations; (however subsidized children requiring maternity care services will be referred to Medicaid).
Diabetic Supplies and Equipment	Coverage includes insulin, blood glucose monitors, blood glucose monitors for visually impaired, data management systems, test strips for monitors and visual reading, urine test strips, insulin, injection aids, cartridges for visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, oral agents.	As prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law.

General Coverage	Scope of Coverage	Level of Coverage
<u>Ostomy Equipment and Supplies</u>	<u>Coverage includes ostomy equipment and supplies used to contain diverted urine or fecal contents outside the body from a surgically created opening (stoma).</u>	<u>As prescribed by a health care provider legally authorized to prescribe under title eight of the education law.</u>
Diabetic Education and Home Visits	Diabetes self-management education (including diet); reeducation or refresher. Home visits for diabetic monitoring and/or education.	Limited to visits medically necessary where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management or where reeducation is necessary. May be provided by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified diagnosis nutritionist, certified dietician or registered dietician upon the referral of a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law and may be limited to group settings wherever practicable.
Emergency, Preventive and Routine Vision Care	Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.	The vision examination may include, but is not limited to: <ul style="list-style-type: none"> ⇒ Case history ⇒ Internal and External examination of the eye ⇒ Ophthalmoscopic exam ⇒ Determination of refractive status ⇒ Binocular balance ⇒ Tonometry tests for glaucoma ⇒ Gross visual fields and color vision testing ⇒ Summary findings and recommendations for corrective lenses
	Prescribed Lenses	At a minimum, quality standard prescription lenses provided by a physician, optometrist or optician are to be covered once in any twelve month period, unless required more frequently with appropriate documentation. The lenses may be glass or plastic lenses.
	Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve month period, unless required more frequently with appropriate documentation. If medically warranted, more than one pair of glasses will be covered.
	Contact Lenses	Covered when medically necessary.

General Coverage	Scope of Coverage	Level of Coverage
Diagnosis and Treatment of an Autism Spectrum Disorder	Coverage for the Screening, Diagnosis and Treatment of Autism Spectrum Disorders	Includes the following care and assistive communicative devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: <ul style="list-style-type: none"> ⊖ Behavioral health treatment; ⊖ Psychiatric care; ⊖ Psychological care; ⊖ Medical care provided by a licensed health care provider; ⊖ Therapeutic care, including therapeutic care which is deemed habilitative or non-restorative; and ⊖ Pharmacy care. Applied behavioral analysis shall be covered. Assistive communication devices shall be covered when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means such as speech or in writing. Assistive communication devices such as communication boards and speech-generating devices may be rented or purchased, subject to prior approval. Coverage must include dedicated communication devices, which are devices that generally are not useful to a person in the absence of a communication impairment. Items such as laptops, desktops, or tablet computers are not covered items but software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device is a covered item.
Emergency, Preventive and Routine Dental Care	Emergency Dental Care	Includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.
	Preventive Dental Care	Includes procedures which help prevent oral disease from occurring, including but not limited to: <ul style="list-style-type: none"> ⊖ Prophylaxis: scaling and polishing the teeth at 6 month intervals ⊖ Topical fluoride application at 6 month intervals where local water supply is not fluoridated ⊖ Sealants on unrestored permanent molar teeth. ⊖ Space Maintenance: unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

	Routine Dental Care	<ul style="list-style-type: none"> ≡ Dental examinations, visits and consultations covered once within 6 month consecutive period (when primary teeth erupt) ≡ X-ray, full mouth x-rays at 36 month intervals, if necessary, bitewing x-rays at 6-12 month intervals, or panoramic x-rays at 36 month intervals if necessary; and other x-rays as required (once primary teeth erupt) ≡ All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization including preoperative care and postoperative care ≡ In office conscious sedation ≡ Amalgam, composite restorations and stainless steel crowns ≡ Other restorative materials appropriate for children
	Endodontics	Includes all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.
	Prosthodontics	<p>Removable: Complete or partial dentures including six months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.</p> <p>Fixed: Fixed bridges are not covered unless</p> <ol style="list-style-type: none"> 1) Required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth; 2) Required for cleft-palate treatment or stabilization; 3) Required, as demonstrated by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis.
		NOTE: Refer to the Medicaid Management Information System (MMIS) Dental Provider Manual for a more detailed description of services.

Orthodontics	<p>Prior approval for orthodontia coverage is required. Includes procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/ mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.</p> <p>Orthodontia coverage is not covered if the child does not meet the criteria described above.</p> <p>Procedures include but are not limited to:</p> <ul style="list-style-type: none">≡ Rapid Palatal Expansion (RPE)≡ Placement of component parts (e.g. brackets, bands)≡ Interceptive orthodontic treatment≡ Comprehensive orthodontic treatment (during which orthodontic appliances have been placed for active treatment and periodically adjusted)≡ Removable appliance therapy≡ Orthodontic retention (removal of appliances, construction and placement of retainers)
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Child Health Plus Benefits Package Exclusions
May 2015

The following services will NOT be covered:

- Experimental medical or surgical procedures.
- Experimental drugs.
- Drugs which can be bought without prescription, except as defined.
- Prescription drugs used for purposes of treating erectile dysfunction.
- Prescription drugs and biologicals and the administration of these drugs and biologicals that are furnished for the purpose of causing or assisting in causing the death, suicide, euthanasia or mercy killing of a person.
- Private duty nursing.
- Home health care, except as defined.
- Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
- Services in a skilled nursing facility.
- Cosmetic, plastic, or reconstructive surgery, except as defined.
- In vitro fertilization, artificial insemination or other means of conception and infertility services.
- Services covered by another payment source.
- Durable Medical Equipment and Medical Supplies, except as defined.
- Transportation, except as defined.
- Personal or comfort items.
- Services which are not medically necessary.

Attachment Related to CHIP Eligibility SPA CS20
NY 19-0025

Due to other system priorities and the small number of children who would not meet one of the 13 exceptions to the waiting period that are programmed into NY State of Health, New York's Health Plan Marketplace, the waiting period has not been removed from the system. Children who do not meet one of the exceptions are manually removed from the waiting period and their enrollment is processed without a waiting period. A monthly report is run to capture children who are found in the waiting period and their determination is manually overridden in the NY State of Health so the child has access to coverage in accordance with current processing rules.