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

Preamble

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

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

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

State/Territory: _____New York State_____
(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/ Judith Arnold_____3/29/10_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Name: _Judith Arnold_____ Position/Title: Director, Division of Coverage and Enrollment

Name: _Gabrielle Armenia_____ Position/Title: Director, Bureau of Child Health Plus Enrollment

Name: _____ Position/Title: _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this Form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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

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

1.1.1 ☒ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); or

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); or

1.1.3. ☐ A Combination of both of the above.

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

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

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

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

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

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

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

The New York State Child Health Plus (CHPlus) and Medicaid programs have a combined enrollment of approximately 2.2 million children.

The following charts depict the uninsured and insured children in New York State for 2005 broken down by income, region and ethnicity. The charts show that 91 percent of the children in the state have credible health insurance coverage.

Children by Coverage, Poverty, and Race/Ethnicity
CPS in 2006, Coverage for 2005

UNINSURED						
Family Income as % of FPL	Region	Race/Ethnicity White Non-Hispanic	Black Non-Hispanic	Hispanic	Other, d.k.	All
000-099%	NYC	3,529	37,524	39,806	4,434	85,293
	ROS	50,609	13,006	13,631		77,246
	All	54,138	50,530	53,437	4,434	16,2539
100-249%	NYC	4,550	12,736	37,304	18,645	73,235
	ROS	40,972	18,140	8,550	3,256	70,917
	All	45,522	30,876	45,854	21,901	14,452
250%+	NYC	14,989	9,691	18,672	7,090	50,442
	ROS	41,153	8,460	4,355	4,043	58,012
	All	56,142	18,151	23,027	11,133	108,454
All	NYC	23,068	59,951	95,782	30,169	208,970
	ROS	132,734	39,606	26,536	7,299	206,175
	All	155,802	99,557	122,318	37,468	415,145

INSURED						
Family Income as % of FPL	Region	Race/Ethnicity White Non-Hispanic	Black Non-Hispanic	Hispanic	Other, d.k.	All
000-099%	NYC	71,346	207,308	238,983	50,119	567,756
	ROS	202,803	63,997	70,308	29,527	366,634
	All	274,149	271,305	309,291	79,646	934,390
100-249%	NYC	103,263	132,882	212,177	75,105	523,427
	ROS	378,835	75,797	94,761	31,839	581,234
	All	482,098	208,679	306,938	106,944	1,104,661
250%+	NYC	337,941	194,269	142,565	93,566	768,341
	ROS	1,299,572	83,000	122,867	92,071	1,597,509
	All	1,637,513	277,269	265,432	185,637	2,365,850
All	NYC	512,550	534,459	593,725	218,790	1,859,524
	ROS	1,881,210	2,22,794	287,936	153,437	2,545,377
	All	2,393,760	757,253	881,661	372,227	4,404,901

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

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

New York State actively pursues all uninsured children in the State through a multifaceted outreach campaign and a simplified enrollment process. The Connections to Coverage Campaign, the Department's 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. Health plans participating in the program also advertise the CHPlus program to solicit enrollment into their plans. Community based facilitated enrollment agencies also reach out to the uninsured to encourage them to apply for health insurance.

Once families learn of the program, the program is geared to help the families enroll their children as easily as possible. Families can enroll their children by applying through the mail, at the health plan of their choice or through a community based organization (CBO).

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

Not applicable.

2.3. Describe the procedures the state uses to accomplish coordination of CHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5.) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

In order to increase coverage for uninsured children in New York State, New York coordinates the enrollment of children in its current CHPlus and Medicaid programs. Families apply for health insurance for their children on one application. They are screened for Medicaid and if found eligible, are enrolled in that program. The Department developed a common application for individuals and families to apply for Family Health Plus, Medicaid and CHPlus. This application is called the Access NY Health Care (Access NY) application.

The Department of Health has reorganized such that the Medicaid and Child Health Plus programs are co-located in the newly created Office of Health Insurance Programs (OHIP). The Division of Coverage and Enrollment within OHIP is responsible for establishing the enrollment policy for Medicaid, Family Health Plus, and Child Health Plus. It ensures that the rules for each program are developed rationally and are clearly disseminated to program partners including local districts, health plans, and facilitated enrollers.

Under the CHPlus program, through the purchase of a managed care insurance product, children have primary care providers who coordinate their health care, including referrals to specialists when appropriate. Whenever possible, CHPlus providers are also Medicaid providers. Children who enroll in Medicaid or CHPlus may experience changes which make them ineligible for one program and eligible for the other. Thus, having most health plans participating in CHPlus program and also participating in Medicaid will allow children the ability to move between insurance programs without changing providers.

New York's CHPlus program also coordinates with the WIC program, a program to improve the nutrition and health of women, infants and children. Applicants to the CHPlus program can also apply to WIC using the Access NY Health Care application.

Coordination with the Title V program also exists. CHPlus staff works with Department staff responsible for Title V programs and with the Child Health Services Block Grant Advisory Council on programmatic issues. Many Title V grantees are facilitated enrollers assisting families in completing applications for health insurance. On the local level, many Title V programs promote CHPlus to their clients and communities. For example:

- Healthy Child Care New York distributes CHPlus materials such as posters and brochures to the child care community in collaboration with the Office of Children and Family Services. The training for child care health consultants, which is done by Title V staff,

includes the topic of health insurance and access to CHPlus; and

- The Community Health Worker Program, the Prenatal Care Assistance Program, the Children with Special Health Care Needs Program, the Comprehensive Prenatal/Perinatal Services Networks and the Childhood Lead Poisoning Prevention Program are all examples of Title V-related programs that provide outreach and education to their clients and their communities about CHPlus. They do this as a means to improve health outcomes for children and families in their communities.

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 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 (Section 2102(b))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

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

4.1.1. ☐ Geographic area served by the Plan:

4.1.2. ☒ Age:

A child is eligible for CHPlus or Medicaid if the child is less than 19 years of age. Documentation of proof of age for CHPlus shall include one of the following: copy of birth certificate; religious documents (baptismal papers); school records; and/or signed affidavit stating witness of birth.

4.1.3. ☒ Income:

Effective September 1, 2008, a child residing in a household having a gross household income at or below 400% of the FPL (as defined and annually revised by the federal Office of Management and Budget) is eligible for CHPlus.

Documentation of income shall include any one of the following: annual Federal and State tax returns, paycheck stubs or other documentation of income; written documentation by employer; or an affidavit of self-income declaration. Gross income for the purposes of this plan means income before deduction of income taxes, employees' social security taxes, insurance premiums, bonds, etc. Gross income includes the following:

1.) Monetary compensation for services, including wages, salary, commissions or fees, (excluding all wages paid by the Census Bureau for temporary employment);
2.) Net income from farm and non-farm employment;
3.) Social Security;
4.) Dividends or interest on savings bonds, income from estates or trusts, or net rental income;
5.) Unemployment compensation;
6.) Government civilian employee or military retirement or pensions or veterans' payments;
7.) Private pensions or annuities;
8.) Alimony or child support payments;
9.) Regular contributions from persons not living in the household;
10.) Net royalties; and
11.) Other cash income.

4.1.4. ☐ Resources (including any standards relating to spenddowns 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. School records, utility bills, rent receipt or any mail addressed to the child and/or responsible adult which has been postmarked may be used as proof of residency.

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:

In addition to the age, income, residency criteria as described above, a child is eligible for CHPlus if, in accordance with Title XXI, the following conditions do not apply:

1. The child is eligible for Medicaid.

2. A child is an inmate of a public institutions or a patient in an institution for mental diseases; or

3. A child is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.

4.1.8. ☒ Duration of eligibility:

The period of eligibility shall commence on the first day of the month during which a child is eligible, as described below, and end on the last day of the twelfth month. 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. Children whose application is received by the 20th of the month shall be enrolled the first day of the next month if determined eligible. Applications received after the 20th 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 submitting the application. Children are recertified annually. Families are required to report to the health plans changes in New York State residency or health care coverage through insurance that may make a child ineligible for subsidy payments. If a family submits revised eligibility information to a plan that affects their eligibility status, the health plan implements this information prospectively. A family may incur a lower or higher family contribution or be referred to Medicaid based on this new information.

A two month presumptive period of eligibility is available to applicant children as a means of providing services under CHPlus when a child appears eligible for the program, but, pertinent documentation is missing. The health plan performs a review of the child's age, family's gross income, residency, and health care coverage, and from the completed application determines whether the child appears eligible. If one or more pieces of the documentation to support these variables are not submitted with the application, the family is allowed up to two months to submit the documentation or the child is disenrolled from the program.

Effective September 1, 2007, if the child appears Medicaid eligible at initial application, health plans will no longer enroll them in CHPlus on a temporary basis. Temporary CHPlus coverage continues to be available to any child under the age of 19 whose family's household income does not exceed 400% of the FPL and appears to be Medicaid eligible at recertification. This eligibility period of temporary enrollment shall continue until the earlier of the date a Medicaid eligibility determination is made or two months after the temporary eligibility period begins. A temporary enrollment period may be extended in the event a Medicaid eligibility determination is not made within the two-month period through no fault of the applicant, as long as all the required documentation has been submitted within the two-month period. Once a child has been determined eligible for Medicaid, the child will be disenrolled from CHPlus at the end of the month the determination was made and the claiming of federal funds for expenditures for such child from the first day of the month in which the child was determined eligible for Medicaid will be transferred from Title XXI to Title XIX. If a child is determined not to be eligible for Medicaid prior to the last day of the two-month temporary eligibility period, such child may continue to be presumed eligible for CHPlus until the earlier of the date a CHPlus eligibility determination is made or the last day of the two-month presumptive eligibility period.

4.1.9. ☒ Other standards (identify and describe):

New York does not require an applicant's social security number as a condition of enrollment but does request the social security number if available. One exception is temporary enrollment. Children who screen eligible for Medicaid are required to provide a social security number.

4.1.10 ☒ Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide coverage to the following otherwise eligible individuals lawfully residing in the United States:

(1) "Qualified aliens" otherwise subject to the 5-year waiting period per section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA);

(2) Citizens of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who have been

admitted to the United States (U.S.) as non-immigrants and are permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;

(3) Individuals described in 8 CFR 103.12(a)(4) who do not have a permanent residence in the country of their nationality and are in statuses that permit them to remain in the U.S. for an indefinite period of time pending adjustment of status. These individuals include:

(a) Individuals currently in temporary resident status as Amnesty beneficiaries pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);
(b) Individuals currently under Temporary Protected Status pursuant to section 244 of the INA;
(c) Family Unity beneficiaries pursuant to section 301 of Public Law 101-649 as amended, as well as pursuant to section 1504 of Pub. L. 106-554;
(d) Individuals currently under Deferred Enforced Departure pursuant to a decision made by the President; and
(e) Individuals who are the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and

(4) Individuals in non-immigrant classifications under the INA who are permitted to remain in the U.S. for an indefinite period, including the following who are specified in section 101(a)(15) of the INA:

- Parents or children of individuals with special immigrant status under section 101(a)(27) of the INA as permitted under section 101(a)(15)(N) of the INA;
- Fiancées of a citizen as permitted under section 101(a)(15)(K) of the INA;
- Religious workers under section 101(a)(15)(R);
- Individuals assisting the Department of Justice in a criminal investigation as permitted under section 101(a)(15)(S) of the INA;
- Battered aliens under section 101(a)(15)(U) (see also section 431 as amended by PRWORA); and
- Individuals with a petition pending for 3 years or more as permitted under section 101(a)(15)(V) of the INA.

☒ The State elects the CHIPRA section 214 option for children up to age 19

☐ The State elects the CHIPRA section 214 option for pregnant women through the 60-day postpartum period

4.1.10.1 ☒ The State provides assurance that for individuals whom it enrolls in CHIP under the CHIPRA section 214 option that it has verified, both 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.

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

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

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

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

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

Eligibility determination for CHPlus is performed by the health plans which provide the services under the program while the eligibility for Medicaid is determined by the Local District Social Services (LDSS) offices.

Families must complete an application to be enrolled in CHPlus or Medicaid. The Access NY Health Care application is available through the health plans participating in the program, the Child Health Plus Hotline and through facilitated enrollers, community-based organizations (CBOs) contracted to provide outreach and application assistance.

To assist families in enrolling, the Department developed a brochure which lists participating health plans and facilitated enrollers by geographic area who can provide application assistance. This brochure also provides a toll-free hotline that applicants can call for more information on enrollment. The Child Health Plus Hotline is a toll free number which answers inquiries about the CHPlus and Medicaid programs and provides information and assistance to the public regarding eligibility and enrollment in both programs. This hotline provides general program description; income and eligibility requirements; family contribution levels; covered benefits; information on the enrollment process and the names and location of participating health plans. Additionally, this hotline provides application assistance by: answering questions about completing the application; screening callers for eligibility; describing the documentation requirements; and assisting families in locating the LDSS offices or a facilitated enroller for additional application assistance.

Families also have the opportunity to have someone assist them in completing the application and to gather the appropriate documentation required for enrollment. The Department has contracted with 41 community based organizations to provide facilitated enrollment services for the Medicaid, Family Health Plus and CHPlus programs. These organizations are responsible for assisting families in completing the Access NY Health Care application, gathering the necessary documentation and submitting the application to a health plan for enrollment in CHPlus or a LDSS office for enrollment in Family Health Plus and Medicaid.

Applications for CHPlus are sent directly to health plans for eligibility determination. The health plans participating in the CHPlus program are responsible for determining eligibility and enrolling children into the CHPlus program. To do this, the health plan accepts an application from the eligible child or a facilitated enroller and reviews the application for completeness and required documentation. If the application is complete and the child is found eligible for the program, the health plan enrolls the child. If the application is complete but all of the documentation is not present, the child is presumptively enrolled and the health plan would request the applicant to submit missing enrollment documentation within two months. If the family fails to provide documentation, the child's coverage will be terminated at the end of the two month period. Effective September 1, 2007, health plans can no longer enroll the child on a temporary basis except at recertification. If the child appears to be Medicaid eligible, the health plan shall either assist the family in enrolling the child in Medicaid by submitting the application to the LDSS, refer the family to a facilitated enroller to assist in the completion and submission of an application, or refer the family to the local Department of Social Services for eligibility determination.

Each enrollee in the CHPlus program must be re-certified annually. The Department has designed and implemented a simplified application at renewal which collects only information that is necessary to determine continued eligibility for CHPlus coverage and is subject to change since the date of initial application. The family must submit an application to the health plan and any required documentation needed to support the information contained on the application. The health plan will review this information against the eligibility criteria to ensure that the child is still eligible for the program. Health plans may enroll a child at renewal if they continue to appear eligible for CHPlus but the family failed to complete certain sections of the renewal application or failed to provide all documentation. They are given a two-month grace period to provide the missing information. Additionally, families now have the option of documenting their income at renewal by supplying the social security numbers of the household members with countable income. The CHPlus subsidy and coverage shall be terminated or not renewed upon annual re-certification for the following reasons: the child reaches the age of 19; the family's gross income exceeds the eligibility criteria; the child is enrolled in Medicaid; the child no longer resides in the service area of the insurer; and/or the child has other health insurance coverage. Children who "age out" of CHPlus are disenrolled from the health plan on the last day of the month in which they

reach 19 years of age. Enrollees are required to notify health plans if their residency or health care insurance coverage changes during the year. These changes can also include an income change which affects their subsidy level or make them appear eligible for Medicaid. The health plan would act accordingly based upon the new information.

The Department audits at least annually each health plan's eligibility verification and recertification procedures to ensure children are enrolled appropriately. This includes an annual review of a statistically valid sample of cases from each health plan. The audit is conducted through site visits and/or desk audits to determine adherence to enrollment policies and procedures.

For the Medicaid program, the methods of establishing eligibility and continuing enrollment are specified in the Title XIX (Medicaid) State Plan.

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

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

The State does not have a waiting list as there is no cap on enrollment.

4.4. Describe the procedures that assure that:

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

The applications used to determine eligibility for CHPlus and Medicaid ask if the prospective enrollee currently has health insurance coverage. If they answer yes to this question, the child is not eligible for CHPlus. If the child does not have health insurance, the health plan determining eligibility for the CHPlus program reviews the application and supporting documentation against the eligibility criteria for the Medicaid and CHPlus programs. The application is first screened for Medicaid eligibility. If the child is not determined eligible for Medicaid, they are reviewed against the eligibility criteria for CHPlus. The screening tool has been determined to be an accurate tool for determining eligibility for both programs. This same process is followed at recertification.

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

Health plans and facilitated enrollers are required to screen all CHPlus applicants for

Medicaid eligibility. If information and/or documentation submitted by the family at the time of application suggest that the family is eligible for Medicaid, the health plan must refer the family to a facilitated enroller or appropriate LDSS office to complete an application for Medicaid. If the health plan is a facilitated enroller, they can assist the family in completing the Access NY application, satisfy the face-to-face interview for Medicaid and submit the completed application and required documentation to the appropriate LDSS for a Medicaid eligibility determination. If the health plan is not a facilitated enroller, they are required to forward the application and documentation to the LDSS office and provide families with information regarding the location of facilitated enrollers and the LDSS offices where families can apply for Medicaid.

Facilitated enrollers are located in communities and are available nights and weekends to assist families in completing the Access NY application. Children who are found ineligible for Medicaid based on the screen, may apply and be enrolled in CHPlus, if otherwise eligible. Documentation of these referrals is required and reviewed at the time of the audit.

The following chart identifies the Medicaid income levels for pregnant women and children:

Individual / Age	**Net Family Income (**Federal Poverty Level **%)**
Pregnant women	<=200% FPL, without an asset test
Children <1	<=200% FPL, without an asset test
Children <6	<=133% FPL, without an asset test
Children 6 – 18	<=100% FPL, without an asset test

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

The use of one application for both children's health insurance programs (CHPlus and Medicaid) facilitates enrollment into the correct program. All children are first screened for Medicaid eligibility. The applications for those children found ineligible for Medicaid are sent to the health plan chosen by the family for enrollment in CHPlus.

Children recertifying for Medicaid, that are found eligible for CHPlus, do not need to complete a new application to enroll in CHPlus. The State will receive electronic files from Medicaid on a weekly basis, indicating those children that appear CHPlus eligible at recertification. Children enrolled in a Medicaid managed care plan that is also a CHPlus plan will be transferred to that plan. If the child is enrolled in a Medicaid Managed Care plan that is not a CHPlus plan, the state will auto-assign the child to a CHPlus health plan. For a child enrolled in fee-for-service Medicaid, the child will be auto-assigned to a plan or in cases where there is only one CHPlus plan in a county, the State will forward the names of those children to that plan.

The health plans will confirm CHPlus eligibility by contacting the families about the presence of other health insurance, access to state health benefits, and to collect any premium contribution that may be owed. Health plans shall not enroll these children in CHPlus presumptively. Once a child is successfully transferred and enrolled in

CHPlus, all rules, policies and procedures applicable to CHPlus enrollees become applicable to that child.

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

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

4.4.4.2. ☒ Coverage provided to children in families over 200% and up to 250% of the FPL. Describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

An evaluation of the CHPlus program has shown that "crowd-out" has not been an issue. The most recent data shows that approximately 2 percent of our new enrollees have dropped insurance from group health plans to enroll in CHPlus. This number is significantly lower than the number we monitor against.

The State monitors prior insurance of applicants to ensure that the program does not substitute for coverage under group health plans. The Access NY application used by the State to enroll children asks if the applicant currently has insurance or if they have had coverage within the past six (6) months. 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. 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.

4.4.4.3. ☒ Coverage provided to children in families above 250% of the FPL. Describe how substitution is monitored and identify specific strategies in place to prevent substitution.

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; or
(j) A child applying for coverage under this provision is at or below the age of five.

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

4.4.4.4. ☐ If the State provides coverage under a Premium Assistance Program, describe:

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

The minimum employer contribution.

The cost-effectiveness determination.

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

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, one of our facilitated enrollment grantees provides application assistance on the St. Regis Mohawk reservation. A referral system has been developed with the tribe and a facilitated enroller provides application assistance two days a week.

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.

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, 2009 through March 31, 2010 to support locally-tailored programs to develop and implement the necessary enrollment infrastructure. 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. The 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 (Section 2103)

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid Plan and continue on to Section 7.

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

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

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

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

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

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

6.1.3. ☒ Existing Comprehensive State-Based Coverage (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; and Pennsylvania.] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97, or one of the benchmark plans. Describe the Fiscal Year 1996 State expenditures for existing comprehensive State-based coverage.

The description of New York's benefit package is attached as Appendix I.

The package is administered through State contracts with participating health plans and was enacted in 1990 through Chapter 922 and 923 of the Laws of 1990 (New York Public Health Law sections 2510 and 2511). The program was further amended through Chapter 731 of the Laws of 1993, Chapter 170 of the Laws of 1994, Chapter 731 of the Laws of 1994, Chapter 80 of the Laws of 1995, the Health Care Reform Act of 1996, Chapter 2 of the Laws of 1998, the Health Care Reform Act of 2000, Chapter 506 of the Laws of 2001,

Chapter 1 of the Laws of 2002, Chapter 62 of the Laws of 2003, Chapter 58 of the Laws of 2004, and Chapter 58 of the Laws of 2005.

The 1996 state expenditures for this program were approximately $71.5 million.

6.1.4. ☐ Secretary-Approved Coverage (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. ☐ Coverage the same as Medicaid State Plan
6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 Demonstration Project
6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage
6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive State-based coverage
6.1.4.6. ☐ Coverage under a Group Health Plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison. (Please provide a sample of how the comparison will be done.)
6.1.4.7. ☐ Other (Describe)

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

6.2.1. ☒ Inpatient Services (Section 2110(a)(1))

- **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. 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.

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. 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.

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.

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

- **Diabetic Supplies and equipment**

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.

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

- **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 (See instructions) (Section 2110(a)(15))

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

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))

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

Level of Coverage: Orthodontic services excluded.

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.

- **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.

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

- **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. 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. (See instructions) (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.

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.

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

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

- **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 (see instructions) (Section 2110(a)(27))

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

- **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.).

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

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

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

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

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

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

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

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

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

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

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

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

Section 7 Quality and Appropriateness of Care

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

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

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

7.1.1. ☒ Quality standards

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;
- 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® 2005), 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
- 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 with in 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:

- 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

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

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. 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.

If an enrollee fails to pay the family contribution of the premium and they do not avail themselves of the review process, the child will be disenrolled from the program. 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))

☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

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

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

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

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state

matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this Title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this Title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

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

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

The 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 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.

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 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.

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 Budget	
STATE:	**FFY Budget**
Federal Fiscal Year	**2010**
State's enhanced FMAP rate	
Benefit Costs	
Insurance payments	
Managed care	$704,776,000
per member/per month rate	*$170*
Fee for Service	
Total Benefit Costs	**$704,776,000**
(Offsetting beneficiary cost sharing payments)	($27,124,000)
Net Benefit Costs	**$677,652,000**
Administration Costs	
Personnel	$1,971,000
General administration	$3,313,000
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	$7,277,000
Other	
Total Administration Costs	**$12,561,000**
10% Administrative Cap	$75,294,667
Federal Share	$448,638,450
State Share	$241,574,550
Total Costs of Approved SCHIP Plan	**$690,213,000**
The Source of State Share Funds:	

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 2010

Fiscal Year	Year End Enrollment	Average Per Member Per Month	Total Benefit Cost	Premium Offset	Net Benefit Cost
2010	327,000	$170.00	$704,776,000	($27,124,000)	$677,652,000

Please note, the FFY 2010 budget reflects 13 months of premium expenditures because only 11 months were paid in FFY 2009.

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

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.

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
November 2009

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.

General Coverage	Scope of Coverage	Level of Coverage
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.
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.

General Coverage	Scope of Coverage	Level of Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	Durable Medical Equipment means devices and equipment ordered by a practitioner for the treatment of a specific medical condition which: ▪ 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. DME intended for use by one person may be custom-made or customized.	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. DME coverage includes equipment servicing (labor and parts). Examples include, but are not limited to: Fitted/Customized leg brace — Not fitted/Customized cane Prosthetic arm — Wheelchair Footplate — Crutches
	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.e.* 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 Devises 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.e.* 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. 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.
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.

General Coverage	Scope of Coverage	Level of Coverage
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.
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	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: ▪ 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.	No limitations.

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.	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: ▪ 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. 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: ▪ 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).

General Coverage	Scope of Coverage	Level of Coverage
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.
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: ▪ Case history ▪ Internal and External examination of the eye ▪ Opthalmoscopic 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.
Emergency, Preventive and	Emergency Dental Care	Includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.

General Coverage	Scope of Coverage	Level of Coverage
Routine Dental Care	Preventive Dental Care	Includes procedures which help prevent oral disease from occurring, including but not limited to: ▪ 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 detention to maintain space for normally developing permanent teeth.
	Routine Dental Care	▪ 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	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. Fixed: Fixed bridges are not covered unless 1) Required for replacement of a single upper anterior (central/lateral incisor or cusped) 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.

Child Health Plus

Benefit Package Exclusions

Article 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.
- Orthodontia Services.
- Services which are not medically necessary.