New York CARTS FY2022 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

1. State or territory name:

New York

2. Program type:

- (●) Both Medicaid Expansion CHIP and Separate CHIP
- ( ) Medicaid Expansion CHIP only
- ( ) Separate CHIP only

3. CHIP program name(s):

Child Health Plus

Who should we contact if we have any questions about your report?

4. Contact name:

Erin Chaskey

5. Job title:

Assistant Bureau Director

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One Commerce Plaza Albany, NY 12210

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PRA Disclosure Statement.
This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather all data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ◉ No

3b. What's the maximum premium a family would be charged each year?

$

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

There is no premium for a child in the Medicaid Expansion category.

5. Which delivery system(s) do you use?
Select all that apply.

- ☑ Managed Care
- ☐ Primary Care Case Management
- ☑ Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

The majority of children in the Medicaid expansion group are enrolled in the Medicaid managed care program.

Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

(•) Yes

2a. Are your premiums for one child tiered by Federal Poverty Level (FPL)?

(•) Yes

( ) No

2b. Indicate the range of premiums and corresponding FPL ranges for one child.

Premiums for one child, tiered by FPL

FPL starts at		FPL ends at
160	→	400

Premium starts at		Premium ends at
$ 9	→	$ 60

( ) No

3. Is the maximum premium a family would be charged each year tiered by FPL?

◉ Yes

3a. Indicate the range of premiums and corresponding FPL for a family.

Maximum premiums for a family, tiered by FPL

FPL starts at		FPL ends at
160	→	400

Premium starts at		Premium ends at
$ 27	→	$ 180

○ No

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

The premium categories are listed below. Households are capped at a maximum of three children. $9 per child per month if household income is between 160-222% FPL ($27/month family maximum); $15/child/ month if household income is between 223-250% FPL ($45/month family maximum); $30/child/month if household income is between 251-300% FPL ($90/month family maximum); $45/ child/month if household income is between 301-350% FPL ($135/month family maximum); $60/child/month if household income is between 351-400%FPL ($180/ month family maximum).

5. Which delivery system(s) do you use?
Select all that apply.

- [x] Managed Care
- [ ] Primary Care Case Management
- [ ] Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

All children enrolled in New York's separate CHIP Program, Child Health Plus, are enrolled in a participating managed care plan.

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ( ) Yes
- (•) No
- ( ) N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrollees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to the substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made changes to any other policy or program areas?

- ○ Yes
- ◉ No
- ○ N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrolees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to substitution of coverage policies?
For example: removing a waiting period.

- ◉ Yes
- ○ No
- ○ N/A

10. Have you made any changes to an enrollment freeze and/or enrollment cap?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made any changes to coverage for your CHIP pregnant individuals eligibility group?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

17. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ○ Yes
- ◉ No
- ○ N/A

18. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

19. Have you made changes to any other policy or program areas?

- ○ Yes
- ◉ No
- ○ N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

Flexibilities made to the Separate CHIP program, Child Health Plus, as outlined in approved CHIP SPA NY-20-0028, remain in effect as a result of the extension of the COVID 19 public health emergency.

21. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- ◉ Yes
- ○ No

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

Program	Number of children enrolled in FFY 2021	Number of children enrolled in FFY 2022	Percent change
Medicaid Expansion CHIP	292,073	294,606	0.867%
Separate CHIP	339,389	329,072	-3.04%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey. Due to the impacts of the COVID-19 PHE on collection of ACS data, the Census Bureau did not release standard one-year ACS estimates in 2020 and that row is intentionally left blank.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2013	Not Available	Not Available	Not Available	Not Available
2014	Not Available	Not Available	Not Available	Not Available
2015	61,000	6,000	1.4%	0.1%
2016	58,000	7,000	1.3%	0.2%
2017	57,000	7,000	1.3%	0.2%
2018	52,000	6,000	1.2%	0.1%
2019	44,000	5,000	1.1%	0.1%
2020	Not Available	Not Available	Not Available	Not Available
2021	51,000	6,000	1.2%	0.1%

Percent change between 2019 and 2021
9.09%

1. What are some reasons why the number and/or percent of uninsured children has changed?

From 2019 to 2020, the uninsured rate slightly increased slightly from 1.1% to 1.2% due to an increase of approximately 7,000 additional uninsured children reported in 2021. This increase is likely a result of the unprecedented number of job losses that occurred in the early months of the pandemic.

2. Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

- ○ Yes
- ◉ No

3. Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

◉ Yes

3a. What is the alternate data source or methodology?

TABLE ID: C27016 SURVEY/PROGRAM: American Community Survey VINTAGE: 2021 DATASET: ACSDT1Y2021 PRODUCT: ACS 1-Year Estimates Detailed Tables UNIVERSE: Civilian noninstitutionalized population for whom poverty status is determined

3b. Tell us the date range for your data

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

3c. Define the population you're measuring, including ages and federal poverty levels.

Civilian noninstitutionalized population under 19 years old for whom poverty status is determined.

3d. Give numbers and/or the percent of uninsured children for at least two points in time.

3.24% for CY2021, 2.82% for CY2019. *Please note, only experimental data is available for CY2020

3e. Why did your state choose to adopt this alternate data source?

Since New York has an S-CHIP program that goes up to 400% FPL, it was determined that the C27016 table was most appropriate in order to see uninsured statistics based on poverty status.

3f. How reliable are these estimates? Provide standard errors, confidence intervals, and/or p-values if available.

Just as reliable, as it is still amongst the data included within the American Community Survey.

3g. What are the limitations of this alternate data source or methodology?

None.

3h. How do you use this alternate data source in CHIP program planning?

To view uninsured population based on poverty status.

○ No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

The provisions of the Public Health Emergency and requirements under the Families First Coronavirus Response Act have caused some Child Health Plus enrollees to shift to Medicaid due to a decrease in household income, causing a slight reduction in overall enrollment in New York's Child Health Insurance Program. Although New York had a slight increase in the number of uninsured children from 2019 to 2020, New York still has one of the lowest uninsured rates in the country. https://kidshealthcarereport.ccf.georgetown.edu/ We will continue to implement targeted outreach efforts to reach children among populations with the highest uninsured rate. *Please note, SEDS data is still not populating in Part 1 table for 2021, table has been uploaded as an attachment.

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.

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NYSEDSTable.pdf

Program Outreach

1. Have you changed your outreach methods in the last federal fiscal year?

◉ Yes

1a. What are you doing differently?

Because New York State has an integrated eligibility and enrollment system, much of the outreach work is geared toward promoting NY State of Health and the programs available through the Marketplace, including Medicaid and Child Health Plus. Specific outreach is not done for each program. In addition to a media campaign promoting NY State of Health, other campaign strategies include developing community partnerships, conducting outreach at community events, making presentations to provide education about NY State of Health, training community partners about the available health insurance options and raising public awareness about the programs available on NY State of Health. During this past year, changes were made to the outreach program strategies to conduct more events in-person as opposed to the previous year. While the COVID-19 public health emergency continued, many in-person events resumed that were done virtually the year before, especially during warmer weather, at times when COVID-19 rates were low and at outside events such as farmer's markets and festivals. This hybrid approach provided an in-person presence at some events but also included a virtual platform when appropriate. While outreach staff continued their work with community-based human service organizations serving children and their families, faith-based institutions, schools, community colleges, organizations offering English as a Second Language (ESL), GED and workforce development classes, Volunteer Income Tax Assistance (VITA) organizations and other local and state government agencies, some of their work occurred on a virtual platform. Partnering with community-based organization has proven to be a successful strategy in conducting outreach to 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 tailor outreach strategies after assessing the demographics of a community and the capacity of an organization. Providing more targeted, local outreach efforts is more effective as we continue to try to enroll hard-to-reach populations. Some examples of our outreach work for this reporting period include: • Partnerships with State Government: The Department continues to partner with the New York State Department of

Labor (DOL) Rapid Response staff to provide information on health insurance options to populations of workers who are being laid off or have already been laid off. When DOL is advised an employer will be laying off employees, they schedule Rapid Response sessions to inform workers of unemployment benefits, as well as other benefits they are entitled to. DOL Rapid Response Specialists contact Department outreach staff and invite a representative to attend these sessions to present the health insurance options available to them. These presentations are predominantly covered by NYS Department of Health Navigators and Marketplace Facilitated Enrollers, depending on the location of the event and availability. Many children whose parents have been laid off are eligible for coverage through Child Health Plus, which, for many families, is a much more affordable option than COBRA coverage. Due to the current Public Health Emergency, Department of Labor offers both virtual and in-person Rapid Response sessions to businesses. The virtual Rapid Response sessions include four or five slides provided by the Department that describe coverage available through NY State of Health. In-person Rapid Response sessions include a more detailed PowerPoint provided by the NY State of Health that features financial assistance available through the American Rescue Plan, information about how to enroll and presenters hand out information and business cards for appointments. • The VITA Program offers free tax help for low-to moderate-income families during the income tax season. For tax year 2021, families earning $57,000 and less are eligible for free in-person tax preparation services through the VITA program. Uninsured children in families of this income range were eligible for free or low-cost subsidized health care coverage under Medicaid and Child Health Plus, many families were also eligible for other Insurance Affordability Programs under subsidized Qualified Health Plans (Advanced Premium Tax Credits and/or Cost Sharing Reductions). NY State of Health and Assistor agencies continue to support the VITA effort by providing information on the VITA efforts by the Capital District CASH Coalitions to community-based organizations, clergy, hospitals, schools, youth programs, and clinic contacts in the Capital District. • The Department has made and distributed outreach materials including flyers, brochures, rack cards and other health education materials to promote the availability of coverage options through NY State of Health. During the

public health emergency, this information was distributed electronically as many locations would not allow information to be physically left. Effectiveness of our campaign is measured by tracking the number of referrals generated through various in person or virtual outreach activities, gathering information on the number of families participating in these activities and how much literature was distributed, either in hard copy or virtually. • A calendar is available on the NY State of Health Website where assistors can post their outreach events. The Department also sends information to assistors regarding various events held throughout the state to enlist the help of Navigators, Certified Application Counselors and Marketplace Facilitated Enrollers. Assistors are able to sign up to participate at these events using Sign up Genius. During the reporting period, assistors signed up for 182 outreach events at locations such as food pantries, libraries, pharmacies, career fairs, health fairs and festivals. 2 of these events included an opportunity to enroll with individuals. 4 of these opportunities were held virtually. 39 events were part of a larger series of events across the state in which NY State of Health partnered with community-based organizations at COVID-19 Vaccine Distribution sites, including a "Vax to School" campaign. Co-locating enrollment assistance with vaccine distribution pods in areas where uninsured rates are high is a new strategy that began last fall and is expected to continue in the future. In addition, NY State of Health has engaged in a multi-pronged outreach campaign encouraging individuals to "Stay Connected" by updating their contact information so that when the public health emergency ends and renewals resume, individuals will receive important information so they will maintain their coverage. This campaign will have multiple phases and will continue during the unwind of the public health emergency.

○ No

2. Are you targeting specific populations in your outreach efforts?
For example: minorities, immigrants, or children living in rural areas.

(●) Yes

2a. Have these efforts been successful? How have you measured the effectiveness of your outreach efforts?

State and locally targeted outreach efforts are developed in conjunction with Navigators, Marketplace Facilitated Enrollers and Certified Application Counselors to address specific populations in need of health care coverage. Many Navigators agencies target specific communities that are hard-to-reach. The effectiveness of these efforts is measured by increases in the number of applications completed by Navigators, Marketplace Facilitated Enrollers and Certified Application Counselors which can be seen through their individual dashboards on NY State of Health.

( ) No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

The Department has found that local community partnerships have been a very effective way of reaching the target population. By engaging groups such as schools, health care providers, faith-based organizations, food pantries and other government entities, we are able to reach potentially eligible children and families that may not otherwise be reached. We measure the effectiveness by tracking the number of events, presentations and trainings and informational materials provided, as well as the number of applicants assisted by Navigators, Marketplace Facilitated Enrollers and Certified Application Counselors. The Department also believes that a coordinated outreach campaign is an effective strategy to reach low-income children and families. NY State of Health engages in a multi-faceted outreach campaign for all programs available on the Marketplace during the Open Enrollment Period. This includes a digital advertising campaign, print advertising and radio and television advertising built around a particular theme. These campaigns increase enrollment in all programs. NY State of Health also engaged in an outreach campaign focusing on individuals "Staying Connected" by updating their accounts to ensure that they receive important information about their coverage. Additional phases of this campaign will occur during the public health emergency unwind, encouraging individuals to renew their coverage.

4. Is there anything else you'd like to add about your outreach efforts?

No.

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1. Do you track the number of CHIP enrollees who have access to private insurance?

- (●) Yes

  1a. What percent of CHIP enrollees had access to private insurance at the time of application?

  1.2

- ( ) No

- ( ) N/A

2. Do you match prospective CHIP enrollees to a database that details private insurance status?

- (●) Yes

  2a. Which database do you use?

  State Employees Health Insurance Plan

- ( ) No

- ( ) N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

.6 %

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

- ○ Yes
- ◉ No
- ○ N/A

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting these data?

Question 3 is not fully appearing so including full question and response here: What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage? .6%

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1. Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?

- (●) Yes

  1a. What percent of children are presumptively enrolled in CHIP pending a full eligibility determination?

  11 %

  1b. Of the children who are presumptively enrolled, what percent are determined fully eligible and enrolled in the program (upon completion of the full eligibility determination)?

  42 %

- ( ) No
- ( ) N/A

2. In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

- (●) Yes
- ( ) No

3. Do you send renewal reminder notices to families?

◉ Yes

3a. How many notices do you send to families before disenrolling a child from the program?

NY State of Health sends a renewal reminder notice 60 days before the end of the coverage period. The notice goes to all family members that are scheduled to renew their coverage.

3b. How many days before the end of the eligibility period did you send reminder notices to families?

While additional reminder notices are not sent after the initial notice, health plans make phone calls to their enrollees reminding them it is time to renew their coverage. If needed, assistance is provided in completing the renewal process during the course of this call.

○ No

4. What else have you done to simplify the eligibility renewal process for families?

New York initially attempts to administratively renew individuals who selected that as an option at their initial enrollment. As long as the individual agrees with the decision of the administrative renewal, the enrollee does not need to do anything additional to renew their coverage.

5. Which retention strategies have you found to be most effective?

Providing telephone outreach is one of the most effective retention strategies. Health plans receive a report of all of the children enrolled in the program through their plan who are scheduled for renewal approximately 45 days prior to the end of their coverage period. Health plans use this report to make reminder outreach phone calls encouraging people to renew. They can also assist with the renewal process if necessary. Application assistors can run reports from their assistor dashboards which show when individuals they assisted are due to renew their coverage. Assistors outreach to these individuals to help them with the renewal process.

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

NY State of Health runs reports showing the percentage of enrollees that successfully renew their coverage. This includes the percentage that are administratively renewed and those that are manually renewed.

7. Is there anything else you'd like to add that wasn't already covered?

Question 1 subparts not fully appearing in report, including full question and answer here: a. What percent of children are presumptively enrolled in CHIP pending a full eligibility determination? 11% b. Of the children who are presumptively enrolled, what percent are determined fully eligible and enrolled in the program (upon completion of the full eligibility determination)? 42% Please note, responses to questions 3, 4, 5 and 6 describe normal process outside of the PHE.

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2022?
Don't include applicants being considered for redetermination - these data will be collected in Part 3.

643010

2. How many applicants were denied CHIP coverage for procedural reasons?
For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

3115

3. How many applicants were denied CHIP coverage for eligibility reasons?
For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

639889

3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

573854

4. How many applicants were denied CHIP coverage for other reasons?

<11

5. Did you have any limitations in collecting these data?

There are no limitations for this reporting year. For the 2022 FFY New York was able to leverage a statistical report generated from our integrated eligibility system, the New York State of Health Marketplace to report CHIP denials, which shows the most frequent reason for a denial of CHIP coverage in the past FFY was because a child was found eligible for Medicaid. In prior years, New York data was limited to the Knowledge Information and Data System (KIDS), which only captured payment denials that resulted from an internal matching process against NY health insurance programs.

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	100%
Denied for procedural reasons	0.48%
Denied for eligibility reasons	99.51%
Denials for other reasons	0%

Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in CHIP in FFY 2022?

2. Of the eligible children, how many were then screened for redetermination?

3. How many children were retained in CHIP after redetermination?

4. How many children were disenrolled in CHIP after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b. How many children were disenrolled for eligibility reasons?
This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

4c. How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting these data?

As previously discussed, NY CHIP enrollees have been extended at their renewal during the PHE, in accordance with our approved CHIP SPA NY-20-0028.

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	
Children retained after redetermination	
Children disenrolled after redetermination	

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in Medicaid in FFY 2022?

2. Of the eligible children, how many were then screened for redetermination?

3. How many children were retained in Medicaid after redetermination?

4. How many children were disenrolled in Medicaid after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b. How many children were disenrolled for eligibility reasons?
This could be due to an income that was too high and/or eligibility in CHIP instead.

4c. How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting these data?

During the COVID-19 public health emergency, New York has not completed redeterminations in Medicaid due to the FFCRA requirement to not disenroll consumers from Medicaid.

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	
Children retained after redetermination	
Children disenrolled after redetermination	

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 5: Tracking a CHIP cohort over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of

the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2022) and six months later (July - Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2023) and 18 months later (July - Sept 2023). If data are unknown or unavailable, leave it blank - don't enter a zero unless these data are known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

◉ Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP in December 2021.

○ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
1890	4375	5816	2753

July - September 2022 (6 months later)

4. How many children were continuously enrolled in CHIP six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
1607	3821	5186	2450

5. How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
38	69	70	27

6. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	<11	<11	<11

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
245	485	560	276

8. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
121	191	211	113

9. Is there anything else you'd like to add about your data?

No.

January - March 2023 (12 months later): to be completed next year
Next year you'll report data about your cohort for this section.

10. How many children were continuously enrolled in CHIP 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in CHIP 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Part 6: Tracking a Medicaid Cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report the number of

children identified at the start of the cohort (Jan-Mar 2022) and six months later (July-Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2023) and 18 months later (July-Sept 2023). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

◉ Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in Medicaid in December 2021.

○ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

◉ Yes

○ No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
32947	19289	23709	10375

July - September 2022 (6 months later)

4. How many children were continuously enrolled in Medicaid six months later? Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
30598	16720	20749	9203

5. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
86	180	234	91

6. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
11	36	65	38

7. How many children were no longer enrolled in Medicaid six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
2263	2389	2726	1081

8. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
40	144	220	109

9. Is there anything else you'd like to add about your data?

No.

January - March 2023 (12 months later): to be completed next year
Next year, you'll report data about your cohort for this section.

10. How many children were continuously enrolled in Medicaid 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in Medicaid 18 months later?
Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
- Transferred to another health insurance program other than Medicaid
- Didn't meet eligibility criteria anymore
- Didn't complete documentation
- Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

1. Does your state require cost sharing?

- (●) Yes
- ( ) No

2. Who tracks cost sharing to ensure families don't pay more than the 5% aggregate household income in a year?

- ○ Families ("the shoebox method")
- ○ Health plans
- ○ States
- ○ Third party administrator
- ◉ Other

2b. Who tracks cost sharing?

The only cost sharing applicable to children enrolled in the Child Health Plus program is the monthly family premium contribution for households with income between 160 and 400 percent of the federal poverty level. The premium contribution levels were set by the State to ensure that no child would exceed the five percent aggregate maximum for these premium contributions, therefore tracking is not necessary.

3. How are healthcare providers notified that they shouldn't charge families once families have reached the 5% cap?

N/A

4. Approximately how many families exceeded the 5% cap in the last federal fiscal year?

N/A

5. Have you assessed the effects of charging premiums and enrollment fees on whether eligible families enroll in CHIP?

- ○ Yes
- ◉ No

6. Have you assessed the effects of charging copayments and other out-of-pocket fees on whether enrolled families use CHIP services?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add that wasn't already covered?

As previously discussed, New York has allowed children to remain enrolled in the Child Health Plus program who failed to pay their monthly family premium contribution. This easement will be in effect through the duration of the public health emergency and was approved in NY CHIP SPA NY-20-0028.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage

through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

- ○ Yes
- ◉ No

Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

- ◉ Yes
- ○ No

2. Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

- ◉ Yes
- ○ No

3. Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

- (●) Yes
- ( ) No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

The Child Health Plus program works in conjunction with the Medicaid Managed Care program to administer the safeguards for the prevention, investigation and referral of cases of fraud and abuse. The safeguards established to accomplish this task are as follows: Provider Network Reviews: • Provider network reviews are conducted to ensure that provider networks are adequate and that they do not include disciplined or sanctioned providers. • All managed care organizations are required to credential providers prior to them providing treatment to members. Re-credentialing activities must be conducted at least once every three years. • Every managed care organization is required to periodically submit its entire provider network to the state via our secure Health Provider Network. Each network is reviewed to ensure that disciplined or sanctioned providers are not included. Child Health Plus provider networks are reviewed at least annually. If a disciplined or sanctioned provider is found to be included, the Department notifies the managed care organization in writing via a warning letter or a statement of deficiency letter, both of which require that the provider be removed from the network. Onsite Surveys of Credentialing/Re-credentialing Processes: • Onsite surveys are conducted every two years to ensure that managed care organizations credential and re-credential providers appropriately. • Follow-up reviews are conducted in the off year to ensure that deficiencies, if any, are addressed. Fraud and Abuse Prevention Plans (10 NYCRR Part 98-1.21): • Managed care organizations that participate in public or government sponsored programs and have more than 10,000 enrollees annually must submit a fraud and abuse prevention plan to the Department. Health maintenance organizations that file fraud and abuse prevention plans with the State Insurance Department (SID) are exempt from this requirement. Health maintenance organizations submit fraud and abuse prevention plans to SID while prepaid health service plans submit fraud and abuse prevention plans to the Department of Health. • In accordance with the regulations, Department fraud and abuse prevention plans were initially due on January 1, 2007 and implemented within six months after they were approved. • Fraud and abuse prevention plans must include the creation of a full time separate Special Investigation Unit (SIU) at each health plan. They must also include procedures for identifying and preventing possible fraud and abuse, investigating suspect cases, and detecting repetitive fraud. In addition, the prevention plans must verify that the organizations will do the following: ensure confidential

reporting; guarantee that the Department of Health will have access to all information and records; promptly investigate suspect cases and implement corrective actions; agree to coordinate with other managed care organizations, as needed; develop a fraud and abuse prevention manual; provide in-service training for employees; establish, apply and disseminate disciplinary policies to employees; and take action to deal with employees who fail to follow applicable standards. • Managed care organizations are also required to submit confirmed cases of fraud and abuse to the Department on an ongoing basis. Such information must include a description of the suspected fraud or abuse, the person(s) involved, the approximate dollar amount and the disposition of the case. • Managed care organizations must submit an annual report which is due on the January 15 (Part I) and May 1 (Part II) each year. The report must address the organizations: experience, performance, and cost effectiveness in implementing their fraud and abuse prevention plan; anticipated modifications to improve performance or remedy observed deficiencies; and the number of fraud and abuse complaints.

5. Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

◉ Yes

5a. What safeguards and procedures do the Managed Care plans have in place?

As previously described above, managed care organizations that participate in government sponsored insurance programs and have more than 10,000 enrollees, annually must submit a fraud and abuse prevention plan to the Department of Health. Fraud and abuse prevention plans must include the creation of a full time separate Special Investigation Unit (SIU) at each health plan. They must also include procedures for identifying and preventing possible fraud and abuse, investigating suspect cases, and detecting repetitive fraud. In addition, the prevention plans must verify that the organizations will do the following: ensure confidential reporting; guarantee that the Department of Health will have access to all information and records; promptly investigate suspect cases and implement corrective actions; agree to coordinate with other managed care organizations, as needed; develop a fraud and abuse prevention manual; provide in-service training for employees; establish, apply and disseminate disciplinary policies to employees; and take action to deal with employees who fail to follow applicable standards. Managed care organizations are also required to submit confirmed cases of fraud and abuse to the Department on an ongoing basis. Such information must include a description of the suspected fraud or abuse, the person(s)involved, the approximate dollar amount and the disposition of the case. Managed care organizations must submit an annual report which is due on January 15th (Part I) and May 1st (Part II) each year. The report must address the organization's experience, performance, and cost effectiveness in implementing their fraud and abuse prevention plan, anticipated modifications to improve performance or remedy observed deficiencies, and the number of fraud and abuse complaints.

- [ ] No
- [ ] N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2022?

302

7. How many cases have been found in favor of the beneficiary in FFY 2022?

103

8. How many cases related to provider credentialing were investigated in FFY 2022?

3

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2022?

2

10. How many cases related to provider billing were investigated in FFY 2022?

432

11. How many cases were referred to appropriate law enforcement officials in FFY 2022?

101

12. How many cases related to beneficiary eligibility were investigated in FFY 2022?

<11

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2022?

<11

14. Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- (●) CHIP only
- ( ) Medicaid and CHIP combined

15. Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

- (●) Yes

  15a. How do you provide oversight of the contractors?

  > Department of Health staff conduct an audit, at least annually. These audits are conducted through desk reviews and reflect a statistically valid sample of cases from each health plan. Case information is reviewed to ensure all CHPlus procedures were followed, including processing of 834 enrollment transactions from NY State of Health, the submission of accurate data to the Knowledge, Information and Data System (KIDS) and that programmatic rules pertaining to the collection of family premium contributions are followed. In conjunction with these audits, program staff also review additional cases for compliance, as needed.

- ( ) No

16. Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

(●) Yes

16a. What specifically are the contractors responsible for in terms of oversight?

The Department of Health relies on contracted health plans to investigate potential cases of fraud and abuse in accordance with their written plans as described above. Health plans are required to report such cases and any patterns of fraud and abuse to the Department of Health as outlined above.

( ) No

17. Is there anything else you'd like to add that wasn't already covered?

No.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups
Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5' group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-18 years) instead.

- (●) Yes
- ( ) No

2. How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
7090	23465	58002	87585	115925	92537

3. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
333	8151	34187	57351	68134	43807

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
304	8120	33860	56646	66952	42315

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.
All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2022?
This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
75	1109	11852	27555	28886	20374

Dental treatment service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6. How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2022?

14532

Sealant codes and definitions
The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

No.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction. For the 2022 CARTS report, the only option for reporting CAHPS results will be through the submission of raw data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database.

1. Did you collect the CAHPS survey?

- (●) Yes

  1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database? Please note this is a requirement for FFY 2022.

  - (●) Yes
  - ( ) No

- ( ) No

Part 2: You didn't collect the CAHPS survey

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.
States can use up to 10% of the total computable amount of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act, 42 CFR 457.10 and 457.618.] States may only claim HSI expenditures after funding other costs to administer their CHIP State Plan.

1. Does your state operate Health Services Initiatives using CHIP (Title XXI) funds? Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

- (●) Yes
- ( ) No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

The Hunger Prevention and Assistance Program

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Low income populations requesting food assistance in NYS from food banks, food pantries, soup kitchens and shelters.

4. How many children do you estimate are being served by the HSI program?

110

5. How many children in the HSI program are below your state's FPL threshold?

110

Computed: 100%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

The program protects the health status of low income children in NYS by ensuring that they have access to nutritious foods. The program protects the health status of low-income children in NYS by ensuring that they have access to nutritious foods. The number of meals provided annually is the metric that measures this program's performance impact. In addition, contractor compliance with food quality standards ensures that nutritious foods are being provided with program funding.

7. What outcomes have you found when measuring the impact?

The quantity and quality of meal services to children has been maintained or increased annually.

8. Is there anything else you'd like to add about this HSI program?

The Hunger Prevention and Nutrition Assistance Program (HPNAP) provides emergency food relief and nutrition services to food insecure populations in New York State. More than 380 million emergency meals are provided through a network of approximately 2,500 Emergency Food Relief Organizations (EFRO). Currently, HPNAP funding supports 45 contracts that include eight regional food banks and 37 Direct Service providers statewide. This slight decrease in number of meals served this reporting period compared to last reporting period could be a result of more children being back to school post COVID restrictions resulting in restored access to programs such as School Breakfast and Lunch (and Summer Food) resulting in less emergency meals needed by children from HPNAP funded organizations.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Opioid Drug Addiction and Opioid Overdose Prevention Program for Schools

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

The Opioid Overdose Prevention Program is Statewide in scope and serves individuals who are at risk of either experiencing an opioid overdose or of encountering one. Program funding is used to train individuals through the State as opioid overdose responders. The public health law was expanded in an amendment effective August 11, 2015 to specifically include school districts, boards of cooperative educational services, county vocational education and extension boards, charter schools and nonpublic elementary and/or secondary schools, as well as persons employed by these districts, boards or schools.

4. How many children do you estimate are being served by the HSI program?

333509

5. How many children in the HSI program are below your state's FPL threshold?

151415

Computed: 45.4%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

The principal metric for measuring the impact of the HSI program is the number of school personnel who have been trained through the OOPP initiative. These trained individuals are positioned for saving lives pending the arrival of EMS.

7. What outcomes have you found when measuring the impact?

More than 42,000 school personnel have been trained in overdose recognition and response since 2015, with nearly 5,900 having been trained in the first nine months of 2022.

8. Is there anything else you'd like to add about this HSI program?

New York State's Opioid Overdose Prevention Program (OOPP) initiative, which began in 2006 and which is managed by the NYS Department of Health in the AIDS Institute's Office of Drug User Health, trains non-medical persons through a network of registered programs to recognize opioid overdoses and to respond appropriately by calling 911 and administering the life-saving antidote, naloxone. The initiative currently has over 900 registered programs, which, in addition to training community members, provide naloxone to them at no cost. NYSDOH furnishes naloxone to the registered programs. Naloxone is the centerpiece in the State's commitment to combatting overdose mortality. In 2015, NYSDOH collaborated with the State Education Department to bring opioid overdose response capacity to the State's secondary school campuses. The initiative's registered programs today include 123 school districts representing 449 distinct schools. In addition to these school districts, many other registered programs, including local health departments, train school personnel. The importance of quick access to naloxone has been exacerbated by the presence of fentanyl, a synthetic opioid 100 times more powerful than heroin, in the illicit drug supply. Fentanyl is increasingly found in non-opioid drugs, including stimulants and pressed pills. This reporting period, the program had an increase in the number of school personnel who have been trained through the OOPP initiative as well as an increase in the number of children served.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Coordinating Care and Supporting Transition for Children and Adolescents and Young Adults with Sickle Cell Disease

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

The sickle cell screening program provides transition services for adolescents and young adults with sickle cell disease and other hemoglobinopathies. The goal of the program is to ensure that adolescents and young adults with sickle cell disease and other hemoglobinopathies are able to transition from pediatric health care and parent-directed control of their health to adult care and self-directed control of their health.

4. How many children do you estimate are being served by the HSI program?

525

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Number of children at three Hemoglobinopathy Centers that kept their transition service appointments. Unable to report on question 5 as this data is only collected on an aggregate level.

7. What outcomes have you found when measuring the impact?

Number of transition readiness assessments completed among children that kept their appointments.

8. Is there anything else you'd like to add about this HSI program?

The Coordinating Care and Supporting Transition for Children and Adolescents and Young Adults with Sickle Cell Disease program supports three Hemoglobinopathy Centers (HC) in New York State to assist adolescents and young adults successfully transition from pediatric to adult/self care. The program goal is to reduce morbidity and mortality in children/AYA with Sickle Cell Disease (SCD) during transition. Transition Navigators at HCs are funded by this program to assist patients with peer support, medication adherence, appointment reminders, disease education, family engagement, specialist referrals and self-management, and refer youth to be trained as youth ambassadors.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

New York State and New York City Poison Control Hotlines

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Upstate NY PC- 54 counties NYCPCC: 8 counties

4. How many children do you estimate are being served by the HSI program?

52142

5. How many children in the HSI program are below your state's FPL threshold?

30309

Computed: 58.13%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

The zip codes where poison control centers focus their educational efforts are prioritized by low income and population density. Poison Control Centers also partner with community groups who are reaching these communities as well (Head Start, WIC, NY Children Services). The Poison Control Centers strive to make sure their hotline is staffed 24 hours a day, 7 days a week, everyday of the year.

7. What outcomes have you found when measuring the impact?

Poison Control Centers have process outcomes that look at the number of events completed in targeted zip codes. When measuring the impact of their hotline, the Poison Control Center identified it was available every day to children across the State.

8. Is there anything else you'd like to add about this HSI program?

The New York State and New York City Poison control hotlines are emergency medical hotlines that take calls from both the public and health care providers regarding intentional and unintentional exposures (which can involve (but not limited to) medications, plants, household chemicals, gases and vapors such as carbon monoxide, drugs of abuse, bites and envenomation). These cases are triaged by Poison Control Center staff. Ideally, patients are kept at home to reduce the use of 911/EMS/ERs if not necessary. If the call is from a health care provider, the staff work as a team member in the treatment of the patient by advising the on site treating team what toxic effects can be seen, what antidotes are available and basic medical management to decrease unnecessary medical expenditure. The Centers' public educational programs are geared to raise awareness and build confidence in our communities with predominantly parent groups (Head Start and WIC) to encourage parents to reach out to poison control prior to calling 911. Since New York's community is so diverse, this brings many challenges with language being one. In addition, NYCPCC works extensively with New York Children's Services (ACS) who have a significant number of families living in homeless shelters. There has been an increase in number of children served since the last reporting period due in part to increase in pediatric exposures.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

The New York State Early Intervention Program (EIP)

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Infants and toddlers birth to age 3 found eligible for the EIP.

4. How many children do you estimate are being served by the HSI program?

68393

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

While EIP does not track family income, approximately more than 50% of the families with children found eligible for EIP services are Medicaid eligible. Child outcome surveys are conducted annually and complied as part of the State's Annual Performance Report to the federal Department of Education to measure children's progress upon exiting the EIP. One metric the EIP program uses to measure the impact of this program on the health of low income children in New York is the percent of children who substantially increased their rate of growth in social skills and behavior by the time they turned 3 years of age or exited the program.

7. What outcomes have you found when measuring the impact?

The most recent report for the EIP program dated February 2022 indicated that over 70% of children substantially increased their rate of growth in social skills and behavior.

8. Is there anything else you'd like to add about this HSI program?

The New York State EIP is part of the national Early Intervention Program for infants and toddlers with disabilities and their families, under the Individuals with Disabilities Education Act (IDEA). The New York State Department of Health (DOH) is designated as the lead agency for the state and is responsible for general administration, supervision and oversight of the program that is administered by the 57 counties and NYC. The mission of the program is to identify and evaluate as early as possible those infants and toddlers whose healthy development is compromised and provide for appropriate intervention to improve the family and child's development. The program is family-centered and supports parents in meeting their responsibility to nurture and enhance their child's development. To be eligible for services, a child must be under three years of age and have a confirmed disability or established developmental delay. A disability means that a child has a diagnosed physical or mental condition that may lead to developmental problems. There was an increase in the number of children served this reporting period as the program returned to pre-pandemic service levels.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another HSI Program in this list?

Optional

Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them are different.
Objective 1 is required. We've provided examples for other objectives, but you can

edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal.

For example: In an effort to reduce the number of uninsured children, our goal is to increase enrollment by 1.5% annually until the state achieves 90% enrollment of all eligible children in the CHIP program.

In an effort to reduce the number of uninsured children, our goal is to increase the number of children enrolled in CHIP by 5% over the next three years.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Rate of uninsured children in New York State in most current survey year.

4. Numerator (total number)

<11

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

Rate of uninsured children under 400% FPL in New York State in base year (2018).

6. Denominator (total number)

<11

Computed: 100%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2018

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ◉ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Limitations in the reporting template only allow for reporting of whole numbers. The uninsured rate of 3.24% in 2021 is slightly higher compared to the reported 2.48% a year ago, 2.82% in 2019, and 3.01% in our base year of 2018. Note due to only having experimental American Community Survey data available for 2020, New York utilized table XK202701 - Age by Health Insurance Coverage, and was not able to capture the uninsured rate by federal poverty level, as is the typical process for this measure. New York has utilized Table C27016 for 2018, 2019 and 2021.

10. What are you doing to continually make progress towards your goal?

The Department is committed to performing a variety of quality improvement and outreach activities in order to decrease the number of children in New York State that do not have access to health insurance.

11. Anything else you'd like to tell us about this goal?

The provisions of the Public Health Emergency and requirements under the Families First Coronavirus Response Act have caused some Child Health Plus enrollees to shift to Medicaid, due to a decrease in household income, causing a slight reduction in overall enrollment in New York's Child Health Insurance Program. As noted earlier in the report, this increase in uninsured is likely a result of the unprecedented number of job losses that occurred in the early months of the pandemic. New York still has one of the lowest uninsured rates in the country. https://kidshealthcarereport.ccf.georgetown.edu/ We will continue to implement targeted outreach efforts to reach children among populations with the highest uninsured rate.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?
Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Increase access to care.

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase access to care for underserved populations, our goal is to increase the number of children of Hispanic ethnicity who have visited a primary care physician by 5% annually over the next five years (ending in 2028).

Increase the number of children 6-12 years of age enrolled in the CHIP program who receive follow-up care after being prescribed ADHD medication by 5% over the next three years.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children of Hispanic ethnicity enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

Children between 6-12 years of age with a new prescription for ADHD medication, who remained on the medication for 210 days, and had at least two follow up visits with a practitioner 9 months after initiation phase.

4. Numerator (total number)

2275

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children of Hispanic ethnicity enrolled in CHIP in the last federal fiscal year.

All eligible children enrolled in Medicaid or CHIP between ages 6-12, newly prescribed ADHD medication.

6. Denominator (total number)

3686

Computed: 61.72%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

This year the percentage decreased from 66.92% to 61.72% whereas in past years, the progress towards our goal remained about the same.

10. What are you doing to continually make progress towards your goal?

The Department is committed to performing a variety of quality improvement activities to enhance the performance of health plans in all areas of child and adolescent health.

11. Anything else you'd like to tell us about this goal?

The COVID-19 pandemic has impacted regular access to care including, preventive care for children and adolescents. We will maintain goal to monitor progress towards increased access to care in the next reporting period.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

Increase the use of preventative care.

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase the use of preventive care in rural communities, our goal is to increase the number of rural children who receive one or more well child visits by 5% annually until relative utilization is equivalent to all other CHIP populations within the state.

Increase the number of children enrolled in the CHIP program 2 years of age who by their second birthday, received all vaccinations in the combination 10 vaccination set by 5% over the next three years.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of rural children who received one or more well child visits in the last federal fiscal year.

Children 2 years of age, who by their second birthday, received all vaccinations in the combination 10 vaccination set. These include: 4 diptheria, tetanus and acellular pertussis (DtaP)vaccinations, 3 polio (IPV) vaccinations, 1 measles, mumps and rubella (MMR) vaccination, 3 haemophilus influenza type B (HiB) vaccinations, 3 hepatitis B (HepB) vaccinations, 1 chicken pox (VZV) vaccination, 4 pneumococcal conjugate (PCV) vaccinations, 1 hepatitus A (HepA) vaccination, 2 or 3 rotavirus (RV) vaccinations, and 2 influenza (flu) vaccines.

4. Numerator (total number)

2272

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of rural children enrolled in CHIP.

All eligible children enrolled in Medicaid or CHIP 2 years of age.

6. Denominator (total number)

5337

Computed: 42.57%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

This year the percentage decreased from 47.71% to 42.57%, whereas last year we had made progress from 45.18% to 47.71%,

10. What are you doing to continually make progress towards your goal?

The Department is committed to performing a variety of quality improvement activities to enhance the performance of health plans in all areas of child and adolescent health. A focus on childhood vaccinations has remained an important component of NYS Department of Health efforts.

11. Anything else you'd like to tell us about this goal?

Despite impacts of COVID-19, the Department supported pediatricians and clinical practices at maintaining preventive visits. We will maintain goal to monitor progress towards better health care status for children enrolled in CHIP.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

Measurement and reporting on these goals will happen through mainstay NYS quality measurement programs (e.g., Quality Assurance Reporting Requirements) and through submission of data to the federal government (e.g., CMS' Medicaid and CHIP Program (MACPro) Portal). The State continues to have health plans report annually for the Quality Assurance Reporting Requirements (QARR) on selected measures pertaining to the Child Health Plus program. Based on the individual plan performance, the State will continue to require plans to respond with acceptable quality improvement initiatives in those areas where problems or potential problems are identified through the QARR reporting process.

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will these data become available?

There are no new plans currently for measuring and reporting on our goals and objectives. COVID-19 has not impacted our public reporting although we caution to some effect that some measures may be impacted by medical record review or the pandemic. Those measure are not included in our goals and objectives here.

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, behavioral health services access, health care equity, special health care needs, or other emerging health care needs.) What have you discovered through this research?

CHIP populations are included in a number of NYS research or demonstration initiatives. For example, CHIP populations are included in the New York State 2019-2021 Kids Quality Agenda Performance Improvement Project (PIP). The NYSDOH recognizes the importance of preventive care in the Medicaid and CHIP pediatric populations. The 2019-2021 PIP focuses areas include: blood lead testing and follow-up, newborn hearing screening and follow-up, and developmental screening.

4. Optional: Attach any additional documents here.
For example: studies, analyses, or any other documents that address your performance goals.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Tell us how much you spent on your CHIP program in FFY 2022, and how much you anticipate spending in FFY 2023 and 2024.

Part 1: Benefit Costs

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 854,585,000	**$** 945,302,000	**$** 1,010,626,000

2. How much did you spend on Fee for Service in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

3. How much did you spend on anything else related to benefit costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 868,073,000	**$** 1,118,636,000	**$** 1,229,957,000

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 60,554,000	**$** 44,150,000	**$** 44,150,000

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2022	FFY 2023	FFY 2024
Managed Care	854585000	945302000	1010626000
Fee for Service	0	0	0
Other benefit costs	868073000	1118636000	1229957000
Cost sharing payments from beneficiaries	60554000	44150000	44150000
Total benefit costs	1783212000	2108088000	2284733000

Part 2: Administrative Costs

1. How much did you spend on personnel in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?
This includes wages, salaries, and other employee costs.

2022	2023	2024
$ 0	**$** 0	**$** 0

2. How much did you spend on general administration in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 25,207,787	**$** 26,342,138	**$** 27,527,534

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

4. How much did you spend on claims processing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

5. How much did you spend on outreach and marketing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 4,161,331	**$** 4,286,171	**$** 4,414,756

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 152,309,667	**$** 156,878,957	**$** 161,585,326

7. How much did you spend on anything else related to administrative costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

Table 2: Administrative Costs
This table is auto-populated with the data you entered above.
Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

	FFY 2022	FFY 2023	FFY 2024
Personnel	0	0	0
General administration	25207787	26342138	27527534
Contractors and brokers	0	0	0
Claims processing	0	0	0
Outreach and marketing	4161331	4286171	4414756
Health Services Initiatives (HSI)	152309667	156878957	161585326
Other administrative costs	0	0	0
Total administrative costs	181678785	187507266	193527616
10% administrative cap	184678222.22	224420888.89	244048111.11

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2022	**FFY 2023**	**FFY 2024**
Total program costs	1843782785	2207295266	2389960616
eFMAP	65	65	65
Federal share	1198458810.25	1434741922.9	1553474400.4
State share	645323974.75	772553343.1	836486215.6

8. What were your state funding sources in FFY 2022?
Select all that apply.

- [x] State appropriations
- [ ] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [ ] Private donations
- [ ] Tobacco settlement
- [ ] Other

9. Did you experience a shortfall in federal CHIP funds this year?

- ( ) Yes
- (•) No

Part 3: Managed Care Costs

Complete this section only if you have a managed care delivery system.

1. How many children were eligible for managed care in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 452,035	**$** 474,637	**$** 498,369

2. What was your per member per month (PMPM) cost based on the number of children eligible for managed care in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 234	**$** 247	**$** 252

	FFY 2022	FFY 2023	FFY 2024
PMPM cost	234	247	252

Part 4: Fee for Service Costs

Complete this section only if you have a fee for service delivery system.

1. How many children were eligible for fee for service in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

2. What was your per member per month (PMPM) cost based on the number of children eligible for fee for service in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 0	**$** 0	**$** 0

	FFY 2022	FFY 2023	FFY 2024
PMPM cost	0	0	0

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

The reduction of projected cost sharing from beneficiaries in Part 1is the result of New York's elimination of the $9 contribution requirement for families between 160% and 222% FPL effective 10/1/22. New York is also projecting increases in per member per month (PMPM) cost due to the addition of services to the CHPlus benefit package in FFY 2023.

2. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

New York continues to prioritize children's health care coverage under the leadership of Governor Hochul. Governor Hochul has demonstrated her commitment to ensuring all children and adults have access to affordable, high quality health insurance through NY State of Health, New York's Health Plan Marketplace. In the 2023 New York State budget, several changes were made in the Child Health Plus program which reflect New York State's commitment to low-income, uninsured children. Effective October 1, 2022, the $9 family premium contribution will be eliminated for children with household income between 160 and 222% of the federal poverty level (FPL). In addition, a significant benefit package expansion was included in the budget, prioritizing mental health services for children and expanding coverage in other areas of need for children. The benefit expansion is scheduled to take effect in January, April and July 2023. Finally, a provision was included to expand post-partum coverage to pregnant individuals in Medicaid and Child Health Plus to twelve months.

2. What's the greatest challenge your CHIP program has faced in FFY 2022?

The greatest challenge New York's CHIP program has faced during FFY 2022 continues to be the COVID-19 public health emergency. During this period, the priority for the Child Health Plus program is to ensure that children obtain coverage and remain insured during the duration of the public health emergency. New York State continues to work diligently to develop plans to unwind the public health emergency with the goal of maintaining coverage for as many children as possible. Elimination of the $9 family premium contribution will help with this goal as children in this income category are historically the group with the largest percentage of disenrollment for non-payment. While plans continue to be developed and refined, the uncertainty of the timing of the wind down continues to be a challenge.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2022?

The Child Health Plus program's greatest accomplishment in FFY 2022 include some significant changes included in the 2023 New York State budget. The first eliminates the $9 family premium contribution for children in households between 160 and 222% of the FPL effective October 1, 2022. The second is a significant benefit expansion which includes several mental health benefits and an expansion of some of the current benefits to more closely align with children's Medicaid coverage in New York State. Finally, post-partum coverage for Medicaid and Child Health Plus will be expanded to twelve months. The reasonable compatibility threshold was also increased with the goal of administratively renewing a greater number of children once the public health emergency ends.

4. What changes have you made to your CHIP program in FFY 2022 or plan to make in FFY 2023? Why have you decided to make these changes?

As mentioned above, in FFY 2023, New York's CHIP program eliminated the $9 family premium contribution for children in households between 160 and 222% of the FPL as of October 1, 2022. Prior to the public health emergency, children in this cohort were disenrolled for failure to pay at a higher percentage than children in higher income households. This change will significantly improve continuity of care and health outcomes for the lowest income subsidized children enrolled in the program. In addition to this change, a significant benefit expansion will be implemented in FFY 2023. The newly added benefits are being added in accordance with recommendations from child health and mental health advocates, providers and consumers and will help fill coverage gaps identified under the program. This includes several mental health benefits including Children and Family Treatment and Support Services (CFTSS), Assertive Community Technology (ACT) and Residential Treatment Services for Youth (RRSY). The benefit expansion also includes Home and Community Based Services (HCBS) and core health services provided in a Voluntary Foster Care Agency (VFCA). Finally, several currently available benefits will be expanded to more closely align with Medicaid coverage in New York. This includes an expansion of the orthodontia benefit, additional coverage for medical supplies and an expansion of the emergency transportation benefit to include air ambulance and transportation between facilities. Post-partum coverage for pregnant individuals will also be expanded to twelve months. In FFY 2023, New York State anticipates taking steps to operationalize the unwind of the public health emergency to ensure that the most children possible remain covered. This includes ensuring that contact information (including mailing address) is current, providing advance notice of enforcement of disenrollment for failure to renew and failure to pay family premium contributions, and adjusting the reasonable compatibility threshold to allow for more children to be renewed administratively. The Child Health Plus program will also be included in statewide efforts to educate consumers on the unwind.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

No.

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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