March 31, 2017

Ms. Kristen Edwards
Centers for Medicare and Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-07-08
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: NYS Child Health Plan
Title XXI Amendment
Effective April 1, 2016

Dear Ms. Edwards:

Pursuant to Title XXI of the Social Security Act, enclosed for your approval is an amendment to New York's State Children's Health Insurance Program State Plan (Title XXI State Plan).

The enclosed state plan amendment requests funding for three health service initiatives, provides retroactive coverage for newborns into Child Health Plus if the family applies for coverage within 60 days of the child's date of birth and adds a provision to reimburse ambulatory behavioral health services provided by Article 28 (DOH), Article 31 (OMH) and Article 32 (OASAS) providers at least at the equivalent of the Ambulatory Patient Group (APG) rate. A revised budget is also included.

Please feel free to contact me at (518) 474-0180 or Gabrielle Armenia of my staff at (518) 473-0566 if you have any questions regarding this matter.

Sincerely,

Judith Arnold
CHIP Director
Director, Division of Eligibility and
Marketplace Integration
Office of Health Insurance Programs

Enclosure

March 31, 2017

Mr. Michael Melendez
Acting Associate Regional Administrator
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health
Jacob K. Javits Federal Building
26 Federal Plaza, Room 37-100 North
New York, NY 10278

Re: NYS Child Health Plan
Title XXI Amendment
Effective April 1, 2016

Dear Mr. Melendez:

Pursuant to Title XXI of the Social Security Act, enclosed for your approval is an amendment to New York's State Children's Health Insurance Program State Plan (Title XXI State Plan).

The enclosed state plan amendment requests funding for three health service initiatives, provides retroactive coverage for newborns into Child Health Plus if the family applies for coverage within 60 days of the child's date of birth and adds a provision to reimburse ambulatory behavioral health services provided by Article 28 (DOH), Article 31 (OMH) and Article 32 (OASAS) providers at least at the equivalent of the Ambulatory Patient Group (APG) rate. A revised budget is also included.

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Sincerely,

Judith Arnold
CHIP Director
Director, Division of Eligibility and
Marketplace Integration
Office of Health Insurance Programs

Enclosure

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

(Req ired nder 4901 of the Balanced B dget Act of 1997 (New section 2101(b)))

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

As a condition for receipt of Federal f nds nder Title XXI of the Social Sec rity Act, (42 CFR, 457.40(b))

/s/ J dith Arnold March 31, 2017
(Signat re of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Ins rance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the req irements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal reg lations and other official iss ances of the Department.

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

Name: J dith Arnold	Position/Title: CHIP Director Director, Division of Eligibility and Marketplace Integration
Name: Gabrielle Armenia	Position/Title: Director, B rea of Child Health Pl s Policy and Exchange Cons mer Assistance
Name:	Position/Title:

***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

Introduction: Section 4901 of the Balanced B dget Act of 1997 (BBA), public law 105-33 amended the Social Sec rity Act (the Act) by adding a new title XXI, the Children's Health Ins rance Program (CHIP). In Febr ary 2009, the Children's Health Ins rance Program Rea thorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 f rther modified the program.

This template o tlines the information that m st be incl ded in the state plans and the state plan amendments (SPAs). It reflects the reg latory req irements at 42 CFR Part 457 as well as the previo sly approved SPA templates that accompanied g idance iss ed to States thro gh State Health Official (SHO) letters. Where applicable, we indicate the SHO n mber and the date it was iss ed for yo r reference. The CHIP SPA template incl des the following changes:

- o Combined the instr ction doc ment with the CHIP SPA template to have a single doc ment. Any modifications to previo s instr ctions are for clarification only and do not reflect new policy g idance.
- o Incorporated the previo sly iss ed g idance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, iss ed November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, iss ed May 11, 2009)
  - Tribal cons ltation req irements (ARRA #2, CHIPRA #3, iss ed May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, iss ed October 7, 2009)
  - Premi m assistance (CHIPRA # 13, SHO # 10-002, iss ed Febr ary 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, iss ed Febr ary 4, 2010)
  - Lawf lly Residing req irements (CHIPRA # 17, SHO # 10-006, iss ed J ly 1, 2010)
- o Moved sections 2.2 and 2.3 into section 5 to eliminate red ndancies between sections 2 and 5.
- o Removed crowd-o t lang age that had been added by the A g st 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing reg lations to implement the CHIPRA req irements. When final reg lations are published in the Federal Register, this template will be modified to reflect those r les and States will be req ired to submit SPAs ill strating compliance with the new reg lations. States are not req ired to resubmit their State plans based on the updated template. However, States m st se the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment nder this stat te, each State m st submit a Title XXI plan for approval by the Secretary that details how the State intends to se the f nds and f lfill other req irements nder the law and reg lations at 42 CFR Part 457. A SPA is approved in 90 days nless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a req est for additional information and restarted after a complete response is received. More information on the SPA review process is fo nd at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states sho ld redline the changes that are being made to the existing State plan and provide a "clean" copy incl ding changes that are being made to the existing state plan.

The template incl des the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section sho ld describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section sho ld provide general information related to the special characteristics of each state's program. The information sho ld incl de the extent and manner to which children in the State c rrently have creditable health coverage, c rrent State efforts to provide or obtain creditable health coverage for nins red children and how the plan is designed to be coordinated with c rrent health ins rance, public health efforts, or other enrollment initiatives. This information provides a health ins rance baseline in terms of the stat s of the children in a given State and the State programs c rrently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section req ires a description that m st incl de both proposed methods of delivery and proposed tilization control systems. This section sho ld f lly describe the delivery system of the Title XXI program incl ding the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan m st incl de a description of the standards sed to determine the eligibility of targeted low-income children for child health assistance nder the plan. This section incl des a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards m st be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State sho ld describe how they will be applied and nder what circ mstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to f lly explain its o treach activities. O treach is defined in law as o treach to families of children likely to be eligible for child health assistance nder the plan or nder other p blic or private health coverage programs. The p rpose is to inform these families of the availability of, and to assist them in enrolling their children in, s ch a program. (Section 2102(c)(1)); (42CFR, 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the req ired scope of health ins rance coverage in a State plan, the child health assistance provided m st consist of any of the fo r types of coverage o tlined in Section 2103(a) (specifically, benchmark coverage; benchmark-eq ivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered nder the plan incl ding the categories nder which that coverage is offered. The amo nt, scope, and d ration of each offered service sho ld be f lly

explained, as well as any corresponding limitations or excl sions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care**- This section incl des a description of the methods (incl ding monitoring) to be sed to ass re the q ality and appropriateness of care and to ass re access to covered services. A variety of methods are available for State's se in monitoring and eval ating the q ality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider sing. In addition to methods, there are a variety of tools available for State adaptation and se with this program. The section lists some of these tools. States also have the option to choose who will cond ct these activities. As an alternative to sing staff of the State agency administering the program, states have the option to contract o t with other organizations for this q ality of care f nction. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the req irement of a State child health plan to incl de a description of its proposed cost sharing for enrollees. Cost sharing is the amo nt (if any) of premi ms, ded ctibles, coins rance and other cost sharing imposed. The cost-sharing req irements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premi ms and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance meas res the State has established for providing child health assistance to targeted low income children nder the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) req ires the State to assess the operation of the Children's Health Ins rance Program plan and submit to the Secretary an ann al report which incl des the progress made in red cing the n mber of nins red low income children. The report is d e by Jan ary 1, following the end of the Federal fiscal year and sho ld cover that Federal Fiscal Year. In this section, states are asked to ass re that they will comply with these req irements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity**- In this section, the State ass res that services are provided in an effective and efficient manner thro gh free and open competition or thro gh basing rates on other public and private rates that are act arially so nd. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that se premi m assistance a description of how it will ass re that applicants and enrollees are given the opport nity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than thro gh that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children thro gh a separate child health ins rance program, thro gh a Medicaid expansion program, or thro gh a combination of these programs. These options are described f rther below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable r les. These states

m st establish enrollment systems that are coordinated with Medicaid and other so rces of health coverage for children and also m st screen children d ring the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.

o **Option to Expand Medicaid-** States may elect to expand coverage thro gh Medicaid. This option for states wo ld be available for children who do not q alify for Medicaid nder State r les in effect as of March 31, 1997. Under this option, c rrent Medicaid r les wo ld apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only thro gh an expansion of Medicaid eligibility wo ld be req ired to complete sections:

- 1 (General Description)
- 2 (General Backgro nd)

They will also be req ired to complete the appropriate program sections, incl ding:

- 4 (Eligibility Standards and Methodology)
- 5 (O treach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration incl ding the b dget)
- 10 (Ann al Reports and Eval ations).

Medicaid Expansion- Medicaid SPA Requirements

States expanding thro gh Medicaid-only will also be req ired to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the req irements for these sections are incorporated by reference thro gh their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Req irements for Children's Health Ins rance)
- 7 (Q ality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections)

o **Combination of Options-** CHIP allows states to elect to se a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of p to 133 percent of poverty thro gh Medicaid and a targeted group of children above that level thro gh a separate child health program. For the children the State chooses to cover nder an expansion of Medicaid, the description provided nder "Option to Expand Medicaid" wo ld apply. Similarly, for children the State chooses to cover nder a separate program, the provisions o tlined above in "Option to Create a Separate Program" wo ld apply. States wishing to se a combination of approaches will be req ired to complete the Title XXI State plan and the necessary State plan amendment nder Title XXIXIX.

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

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Sec rity Blvd
Baltimore, Maryland 21244
Attn: Children and Ad lts Health Programs Gro p
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

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

1.1. The state will se f nds provided nder Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

G idance: Check below if child health assistance shall be provided primarily thro gh the development of a separate program that meets the req irements of Section 2101, which details coverage req irements and the other applicable req irements of Title XXI.

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

G idance: Check below if child health assistance shall be provided primarily thro gh providing expanded eligibility nder the State's Medicaid program (Title XIX). Note that if this is selected the State m st also submit a corresponding Medicaid SPA to CMS for review and approval.

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

G idance: Check below if child health assistance shall be provided thro gh a combination of both 1.1.1. and 1.1.2. (Coverage that meets the req irements of Title XXI, in conj nction with an expansion in the State's Medicaid program). Note that if this is selected the state m st also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

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

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

1.2. ☒ Check to provide an ass rance that expendit res for child health assistance will not be claimed prior to the time that the State has legislative a thority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

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

G idance: The effective date as specified below is defined as the date on which the State

begins to inc r costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State p ts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins o treach or accepting applications).

1.4. Provide the effective (date costs begin to be inc rred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, b t provisions within the SPA may have different implementation dates that m st be after the effective date.

Original Plan
Effective Date:

Implementation Date:

SPA #___, P rpose of SPA_____
Proposed effective date:

Proposed implementation date:

Origin l Submission

Submission d te:	November 15, 1997
Effective d te:	April 15, 2003
Implement tion d te:	April 15, 2003

SPA #1

Submission d te:	M rch 26, 1998
Deni l:	April 1, 1998
Reconsider tion:	M y 26, 1998(Withdr wn)

SPA #2

Submission d te:	M rch 30, 1999
Effective d te:	J nu ry 1, 1999
Implement tion d te	J nu ry 1, 1999

SPA #3

Submission d te:	M rch 21, 2001
Effective d te:	April 1, 2000
Implement tion d te:	April 1, 2000

SPA #4

Submission d te:	M rch 27, 2002
Effective d te:	April 1, 2001
Implement tion d te:	April 1, 2001

SPA #5 (compli nce)

Submission d te:	M rch 31, 2003

SPA #6 (renew l process)

Submission d te:	M rch 22, 2004
Effective d te:	April 1, 2003
Implement tion d te:	April 1, 2003

SPA #7

Submission d te:	M rch 17, 2005
Effective d te:	April 1, 2004 (Upd tes to St te Pl n)
	April 1, 2005 (Ph se-out of Medic id Exp nsion Progr m)
Implement tion d te:	April 1, 2004 (Upd tes to St te Pl n)
	April 1, 2005 (Ph se-out of Medic id Exp nsion Progr m)

SPA #8

Submission d te:	M rch 28, 2006
Effective d te:	April 1, 2005
Implement tion d te:	August 1, 2005

SPA #9

Submission d te:	M rch 28, 2007
Effective d te:	April 1, 2006
Implement tion d te:	April 1, 2006

SPA # 10

Submission d te:	April 3, 2007
Effective d te:	April 1, 2007
Implement tion d te:	April 1, 2007
-gener l inform tion	
Implement tion d te (Proposed):	September 1, 2007
Implement tion d te (Actu l):	September 1, 2008
-exp nsion, substitution str tegies	
Denied:	September 7, 2007
Petition for Reconsider tion:	October 31, 2007
St yed	M rch 17, 2009

SPA # 11

Submission d te:	M y 14, 2007
Effective d te:	September 1, 2007
Implement tion d te:	September 1, 2007

SPA # 12

Submission d te:	M rch 18, 2009
Effective d te:	September 1, 2008
Implement tion d te:	September 1, 2008

SPA # 13

Submission d te:	June 30, 2009
Effective d te:	April 1, 2009
Implement tion d te:	April 1, 2009

SPA # 14

Submission d te:	July 6, 2009
Effective d te:	July 1, 2009
Implement tion d te:	July 1, 2009

SPA # 15

Submission d te:	M rch 29, 2010
Effective d te:	April 1, 2009
Implement tion d te:	April 1, 2009

SPA # 16

Submission d te:	M rch 21, 2011
Effective d te:	April 1, 2010
Implement tion d te:	April 1, 2010

SPA # 17

Submission d te:	M y 20, 2011
Effective d te (Enrollment Center):	June 13, 2011
Effective d te (Medic l Homes Initi tive):	October 1, 2011
Implement tion d te:	June 13, 2011

SPA # 18

Submission d te:	September 20, 2011
Effective d te:	August 25, 2011
Implement tion d te:	August 25, 2011

SPA # 19

Submission d te:	M rch 22, 2012
Effective d te (Medic id Exp nsion):	November 11, 2011
Implement tion d te:	November 11, 2011

SPA # 20

Submission d te:	M rch 31, 2014
Effective d te (utism benefit):	April 1, 2013
Effective d te (other ACA ch nges)	J nu ry 1, 2014
Implement tion d te:	April 1, 2013 nd J nu ry 1, 2014

SPA #21

Submission d te:	M rch 31, 2015
Effective d te:	April 1, 2014
Implement tion d te:	April 1, 2014

SPA #NY-16-0022- C-A

Submission d te:	M rch 28, 2016
Effective d te: (HSI for Poison Control Centers nd Sickle Cell Screening):	April 1, 2015
Effective d te (Ostomy Supplies):	M y 1, 2015
Implement tion d te:	April 1, 2015 nd M y 1, 2015

SPA #NY-16-0022- C – B

Submission d te:	M rch 28, 2016
Effective d te (HSI Medic l Indemnity Fund):	April 1, 2015
Implement tion d te:	April 1, 2015

SPA #NY-17-0023

Submission d te:	M rch 31, 2017
Effective d te (HSI Medic l Indemnity Fund, APG P yments for Ment l He lth):	April 1, 2016
Effective d te (Cover ge for Newborns):	J nu ry 1, 2017
Implement tion d te:	April 1, 2016 nd J nu ry 1, 2017

Superseding Pages of MAGI CHIP State Plan Material

State: New York

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

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

TN No: Approval Date Effective Date _____

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

G idance: The demographic information req ested in 2.1 can be sed for State planning and will be sed strictly for informational p rposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breako ts, income brackets, definitions of ins rability, and geographic location, as well as race and ethnicity. The State sho ld describe its information so rces and the ass mptions it ses for the development of its description.

- Pop lation
- Number of nins red
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (incl ding targeted low-income children and other groups of children specified) identified , by income level and other relevant factors, s ch as race, ethnicity and geographic location, c rrently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, disting ish between creditable coverage nder public health ins rance programs and public-private partnerships (See Section 10 for ann al report req irements). (Section 2102(a)(1)); (42 CFR 457.80(a))

G idance: Section 2.2 allows states to req est to se the f nds available nder the 10 percent limit on administrative expendit res in order to f nd services not otherwise allowable. The health services initiatives m st meet the req irements of 42 CFR 457.10.

2.2. **Health Services Initiatives-** Describe if the State will se the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative f nds, incl ding the cost of each program, and how it is c rrently f nded (if applicable), also update the b dget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

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

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

Program Details

Altho gh there have been many s ccesses in New York's comm nity opioid overdose programs, deaths from overdose contin e to climb. In 2013 there were 637 fatalities involving heroin thro gho t the State, or more than 12 deaths per week. Many overdoses occ r with yo ng people.

Since April 2006, New York State has had a program reg lated by the Department of Health (the Department) thro gh which eligible, registered entities provide training to individ als in the comm nity on how to recognize an overdose and how to respond to it appropriately. The applicable law is Public Health Law Section 3309, and the reg lations are fo nd at Part 80 (80.138) of Title 10 (Health) of the Official Compilation of Codes, R les and Reg lations of the State of New York. These programs are administered within the Department by the Aids Instit te.

The appropriate responses to an opioid overdose incl de calling 911 and administering naloxone (Narcan), an opioid antagonist which reverses the potentially life-threatening conseq ences of an overdose. Eligible entities incl de individ al prescribers (physicians, physician assistants and n rse practitioners), dr g treatment programs, health care facilities, local health departments (LDHs) and comm nity-based organizations that have the services of clinical director.

Program f nding is sed to train individ als thro gho t the State as opioid overdose responders. The public health law was expanded in an amendment effective A g st 11, 2015 to specifically incl de school districts, boards of cooperative ed cational services, co nty vocational ed cation and extension boards, charter schools and nonpublic elementary and/or secondary schools, as well as persons employed by these districts, boards or schools. As s ch, they are expressly a thorized to respond to opioid overdoses thro gh the administration of naloxone. Over 265 programs have registered with the Department, and approximately 100,000 overdose responders have been trained to date.

The opioid program provides ed cation to school staff on how to be a responder sing the kits. The school districts either register with the Department as opioid overdose prevention programs or they work with other eligible organizations that have chosen to register. Altho gh elementary schools are incl ded in the stat tory lang age, the foc s has been on middle and high schools. There is a c rric l m and a mechanism for school staff to be trained in opioid overdose recognition and response. For clarification, the resc e kits are not distrib ted to the pupils, b t rather to school personnel.

Program f nding is also sed to p rchase opioid overdose prevention kits. Each kit is comprised of two m cosal atomizers, two syringes pre-filled with naloxone for se with the atomizers, a breathing mask, nitro gloves, and a zippered bag for containing the s pplies. Naloxone has been s ccessf lly administered more than 2,700 times according to reports that have been submitted to the State. The act al n mber of reversals for which these responders have been responsible is likely to be substantially higher.

To carry o t these objectives, the Department contracts with The Fo ndation for AIDS Research. Payments to this vendor are for trainings, p rchase of overdose prevention kits, and the contract's administrative expenses. These expenses incl de ordering the supplies, maintaining an inventory, interacting with the AIDS Instit te, obtaining competitive pricing, providing reports on a reg lar basis, and working with pharmace tical man fact rers and distrib tors. Overall program monitoring and assessing the achievement of goals involves review of monthly or q arterly narrative and statistical reports that are submitted, as well as onsite program and fiscal monitoring.

Budget and HSI Claiming Details

There are m ltiple f nding so rces for the program, two of which are Department appropriations, located within the Aids Instit te major program. These are General F nd / Local Assistance appropriations, fo nd in the Aid to Localities b dget bill. The General F nd is the State's main operating f nd.

Program estimates that 5% of gross expendit res relate to children age birth thro gh 18. This fig re will be sed to approximate the total f nding for children-related activity. Total expenses will be m ltiplied by 5% to establish the amo nt of f nding related to children age birth thro gh 18. This fig re will then be m ltiplied by the c rrent CHIP federal matching rate of 88% to calc late the amo nt of expenses that can be transferred to CHIP federal f nding.

In the past, there has been a federal f nding component of the program. The federal f nds were an allocation and not a match. However, federal f nds are not c rrently tilized. If federal f nds are sed prospectively, these f nds will be excl ded from the HSI, and only the State f nds will be considered.

Periodic general ledger jo rnal entries will be processed to move the q alified expendit res to CHIP federal f nding. The expenses will be transferred from each f nd so rce according to its percentage of the total f nding. These transactions will be performed in the Statewide Financial System (SFS) and are approved within the Department, and at the Office of the State Comptroller (OSC). Backup doc mentation will be incl ded when the jo rnal entries are processed. There is distinct coding in SFS for the opioid program f nding, and for CHIP funding. There is also a specific program code for CHIP HSI expendit res, to disting ish them from other CHIP expendit res.

Upon SPA approval, a general ledger jo rnal entry or entries will be processed to charge CHIP federal f nding for HSI-related expendit res retroactive to April 1, 2016, the effective date of the SPA. Prospectively, jo rnal entries will be processed to transfer HSI-related expendit res to CHIP federal f nding.

2. Hunger Prevention Nutrition Assistance Program (HPNAP)

Program Details

The H nger Prevention and Nutrition Assistance Program (HPNAP) was established in 1984 as a res lt of public health concerns abo t n trition-related illnesses among persons in need of food assistance. The program is a thorized by Chapter 53, Section 1 of the Laws of 2016, and is administered within the Department by the Center for Comm nity Health, Division of Nutrition, B rea of Nutrition Risk Red ction. HPNAP provides emergency food relief and n trition services to food insec re pop lations in New York State.

HPNAP f nding supports 46 Department contracts, which incl des eight regional food banks and 38 direct service providers statewide. Thro gh these contracts, approximately 240 million emergency meals are provided each year thro gho t the State. HPNAP works with an established network of more than 2,500 Emergency Food Programs (EFP, incl ding food banks, food pantries and soup kitchens, to leverage private and public partnerships.

The goal of the program is to help New Yorkers in need lead healthier, prod ctive and self-s fficient lives, which aligns with the HSI objective of helping low income pop lations. Access to a n tritio s food supply directly improves the health of children. The program leads to increased access to safe and n tritio s food and related reso rces, develops and provides n trition and health ed cation programs and empowers people to increase their independence from emergency food assistance programs.

Each regional food bank has a listing of the services they provide. These incl de safe and n tritio s food to people in need; food transportation and food service eq ipment; assistance in gathering, processing and distrib ting nharvested fresh produce; n trition and health information; and reso rces and g idance thro gh workshops, hando ts and site visits.

A component of the HPNAP program is the J st Say Yes to Fr its and Vegetables (JSY) program, a New York State program that offers n trition ed cation services to families with food insec rity. JSY is a collaboration between the Department and the New York State Regional Food Banks. It is designed to prevent over-weight/obesity and red ce long term chronic disease risks thro gh the promotion of increased fr it and vegetable cons mption. HPNAP and JSY work in partnership with EFPs to improve the health and n trition stat s of people in need of food assistance in the State.

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

Budget and HSI Claiming Details

The main f nding so rce for the program is a Department appropriation, located within the Center for Comm nity Health Program major program. The appropriation is General F nd / Local Assistance, and is in fo nd in the Aid to Localities b dget bill. The General F nd is the State's main operating f nd.

D ring SFY 2015-16, the most recent period for which data are available, the n mber of children served age birth thro gh 17 was 9,407,669, o t of a total pop lation served of 32,671,450. As s ch, it can be asserted that 28.7% of f nding relates to children age birth thro gh 18. Total HPNAP expenses will be m ltiplied by 28.7% to establish the amo nt of f nding related to children age birth thro gh 18. This fig re will then be m ltiplied by the c rrent CHIP federal matching rate of 88% to calc late the amo nt of expenses that can be transferred to CHIP federal f nding.

The contracts associated with these programs se the State f nded appropriation referenced above, b t also a receive a small amo nt of federal f nding thro gh Nutrition-related grants. However, these federal f nds are an allocation and not a match. For the p rpose of the HSI, the federal f nding allocation will be excl ded and only the State f nds will be considered.

Periodic general ledger jo rnal entries will be processed to move the q alified expendit res to CHIP federal f nding. These transactions will be performed in SFS, and are approved within the Department, and at OSC. Backup doc mentation will be incl ded when the jo rnal entries are processed. There is distinct coding in SFS for HPNAP f nding, and for CHIP f nding. There is also a specific program code for CHIP HSI expendit res, to disting ish them from other CHIP expendit res.

Upon SPA approval, a general ledger jo rnal entry or entries will be processed to charge CHIP federal f nding for HSI-related expendit res retroactive to April 1, 2016, the effective date of the SPA. Prospectively, jo rnal entries will be processed to transfer HSI-related expendit res to CHIP federal f nding.

3. Lead Prevention Program and Lead Poisoning Prevention

Program Details

The Lead Prevention Program and Lead Poisoning Prevention are a thorized in Section 1370-1376-a of the New York State Public Health Law. They are administered within the Department by the Centers for Environmental Health's Division of Environmental Health and Food Protection. The Department contracts with local health departments (LHDs), the New York City Department of Health and Mental Hygiene, and Regional Lead Reso rce Centers, to enable the Department to cond ct activities for the elimination of lead poisoning in New York State.

Contracts are established with 57 LDHs to find and red ce so rces of lead before they can harm children; teach the public, health care providers, and others abo t lead; promote lead testing for children and pregnant women to make s re lead poisoning is fo nd as early as possible; help children with lead poisoning by making s re they get the treatment they need; and help families find the so rces of lead in their home.

There is an emphasis on broad pop lation-based o treach, ed cation, policy and system changes, with more intensive efforts targeted to the pop lations at highest risk for lead poisoning. This comprehensive public health approach addresses all aspects of lead poisoning prevention, incl ding: ed cation to families, health care providers, professionals, and the public; s rveillance and data analysis; laboratory reporting and q ality ass rance; promotion and ass rance of childhood lead testing; ass rance of timely, comprehensive medical and environmental management for children with lead poisoning; policy and program activities to advance primary prevention of lead poisoning to red ce expos re before children become lead poisoned; and response to emerging lead-related public health iss es, s ch as lead poisoning among ref gee children and recalls of toys and other cons mer prod cts contaminated with lead.

Children with elevated blood lead levels receive timely and appropriate follow-up services. These medical follow-up services are performed by a health care provider. The specific follow-up care is based on blood test res lts. The act al treatment services provided are not paid with lead program f nding, b t thro gh the ins rance, private or public, of the individ al. The LDHs ens re that best practices/appropriate care is provided in timely manner.

If a child is identified with a blood lead level above reg latory or program limits, a referral is made for environmental intervention. Upon child referral, the LDH or State District Office with j risdiction will assess the ro te of expos re, inspect the ho sing for lead expos re hazards, and enforce the correction of remediation activity. Costs of remediation are borne by the property owner.

The LHDs are responsible for the development and implementation of specific and meas rable work plan activities based on local comm nity assessments in five core program areas (ed cation, primary prevention, s rveillance, screening/blood lead testing, and n rsing environmental follow-up services for children with elevated blood lead levels). The LHDs submit q arterly program reports to the Department that describe progress in achieving work plan objectives with q antifiable meas res for activities, and incl de any accomplishments and/or barriers of effective program operation d ring the q arter. Department staff members cond ct site visits at least once every three years to monitor LHDs.

Regional Lead Poisoning Prevention Reso rce Centers (Centers) submit q arterly narrative reports on work plan activities and participate in q arterly conference calls with Department staff. F nding is provided based on the approval of work plans and b dgets, and contractors are eval ated on their effectiveness in implementing work plan activities. The Centers provide ed cation and medical cons ltation, technical assistance, training and eval ation for health care providers and local health departments across the State. The Centers accept referrals of and provide cons ltation for lead poisoned children, and provide referrals for pregnant women and postpart m for medical treatment as necessary.

Budget and HSI Claiming Details

The main f nding so rce for the program is from New York State Department of Financial Services (DFS) appropriations. The f nding is suballocated, or sent and made available to, the Department via an Inter nit B dget Transfer in SFS.

Program has indicated that 95% of the f nding is for services related to children age birth thro gh 18. Therefore, total State f nds expenses will be m ltiplied by 95% to establish the amo nt of f nding that is related to children age birth thro gh 18. This fig red will then be m ltiplied by the CHIP federal matching rate of 88% to calc late the amo nt of expenses that can be transferred to CHIP federal f nding.

The contracts for these two programs se the State f nded DFS appropriations referenced above, b t also se federal f nding from the Maternal and Child Health Services Block Grant. However, these federal f nds are an allocation and not a match. For the HSI, the federal f nding allocation will be excl ded, and only the State f nds will be considered. Some lead program f nding is claimed as part of Designated State Health Programs (DSHP), b t any s ch f nding will also be excl ded from HSI consideration.

Periodic general ledger jo rnal entries will be processed to move the q alified expendit res to CHIP federal f nding. These transactions will be performed in SFS and are approved within the Department, and at OSC. Backup doc mentation will be incl ded when the jo rnal entries are processed. There is distinct coding in SFS for lead program f nding, and for CHIP f nding. There

is also a specific program code for CHIP HSI expendit res, to disting ish them from other CHIP expendit res.

Upon SPA approval, a general ledger jo rnal entry or entries will be processed to charge CHIP federal f nding for HSI-related expendit res retroactive to April 1, 2016, the effective date of the SPA. Prospectively, jo rnal entries will be processed to transfer HSI-related expendit res to CHIP federal f nding.

Ass rances

New York ass res that the proposed HSI programs described above will not supplant or match CHIP federal f nds with other federal f nds, nor allow other federal f nds to supplant or match CHIP federal f nds.

New York also ass res that all (100 percent) of the f nds transferred (state and federal) are retained by the Opioid Dr g Addiction and Opioid Overdose Prevention Program for Schools, the H nger Prevention Nutrition Assistance Program (HPNAP) and the Lead Prevention and Lead Poisoning Prevention Programs.

2.3-TC **Tribal Consultation Requirements**- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, iss ed May 28, 2009) Section 1902(a)(73) of the Social Sec rity Act (the Act) req ires a State in which one or more Indian Health Programs or Urban Indian Organizations f rnish health care services to establish a process for the State Medicaid agency to seek advice on a reg lar, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations nder the Indian Self-Determination and Ed cation Assistance Act (ISDEAA), or Urban Indian Organizations nder the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these req irements to the Children's Health Ins rance Program (CHIP). Cons ltation is req ired concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State ses to seek advice on a reg lar, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for cons ltation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Incl de information abo t the freq ency, incl siveness and process for seeking s ch advice.

Section 4. Eligibility Standards and Methodology

G idance: States electing to se f nds provided nder Title XXI only to provide expanded eligibility nder the State's Medicaid plan or combination plan sho ld check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed nder section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the b dget to reflect the additional costs if the state will claim title XXI match for these children ntil and if the time comes that the children are eligible for Medicaid.

4.0. ☒ **Medicaid Expansion**

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

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

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

4.1.0 ☒ Describe how the State meets the citizenship verification req irements. Incl de whether or not State has opted to se SSA verification option.

In accordance with Section 211 of the Children's Health Ins rance Program Rea thorization Act of 2009 (CHIPRA), New York State enacted legislation effective October 1, 2010 adding a new eligibility req irement that children applying for Child Health Pl s coverage who declare to be a United States citizen prod ce satisfactory doc mentary evidence of their citizenship stat s and identity. New York State has implemented the data file match process afforded nder CHIPRA to comply with this req irement. Applying children who do not provide their Social Sec rity Number and those children whose citizenship cannot be s ccessf lly verified by the Social Sec rity Administration m st supply doc mentation of United States citizenship and identity.

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

☒ **4.1.2** Ages of each eligibility group, incl ding nborn children and pregnant women (if applicable) and the income standard for that group:

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

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

4.1.3.1-PC ☒ 0% of the FPL (and not eligible for Medicaid) thro gh 400% of the FPL (SHO #02-004, iss ed November 12, 2002)

Effective September 1, 2008, a child residing in a ho sehold having a gross ho sehold income at or below 400 percent of the federal poverty level (as defined and ann ally revised by the federal Office of Management and B dget) is eligible for Child Health Pl s.

☐ **4.1.4** Reso rces of each separate eligibility group (incl ding any standards relating to spend downs and disposition of reso rces):

☒ **4.1.5** Residency (so long as residency req irement is not based on length of time in state):

A child m st be a resident of New York State.

☐ **4.1.6** Disability Stat s (so long as any standard relating to disability stat s does not restrict eligibility):

☒ **4.1.7** Access to or coverage nder other health coverage:

Child m st not be eligible for Medicaid, have other ins rance coverage nless the policy is one of the "Excepted Benefits" set forth in federal Public Health Service Act (accident only coverage or disability income ins rance; coverage iss ed as a supplement to liability ins rance; liability ins rance, incl ding a to ins rance; worker's compensation or similar ins rance; a tomobile medical payment ins rance; credit-only ins rance; coverage for on-site medical clinics; dental only, vision only, or long term care ins rance; specified disease coverage; hospital indemnity or other fixed dollar indemnity coverage; or CHAMPUS/Tricare supplemental coverage) or have a parent or g ardian who is a public employee of the State or public agency with access to family health ins rance coverage by a state health benefits plan where the public agency pays all or part of the cost of the family health ins rance coverage.

4.1.8 ☒ D ration of eligibility, not to exceed 12 months:

The period of eligibility shall commence on the first day of the month d ring which a child is determined eligible, as described below, an end on the last day of the twelfth month of coverage. The period of eligibility shall cease if the child no longer resides in New York State; has access to the New York State Health Ins rance Program or has obtained other health ins rance coverage; has become enrolled in Medicaid; has reached the age of 19; or the applicable premi m payment has not been paid. At the State's discretion, either allow additional time for enrollees to pay o tstanding family premi m contrib tions or waive s ch contrib tions for enrollees living in and/or working in FEMA or Governor declared disaster areas at the time of the disaster event. In the event of a disaster, the State will notify CMS of the intent to provide temporary adj stments to its enrollment and/or re-determination policies, the effective dates of s ch adj stments and the co nties/areas impacted by the disaster.

Effective Jan ary 1, 2014, children whose application is submitted to New York State of Health (NY State of Health), New York's Health Ins rance Marketplace, by the 15th of the month, shall be enrolled on the first day of the next month if determined eligible. Applications received by NY State of Health after the 15th day of the month will be processed for the first day of the second subseq ent month. In no case is a child enrolled more than 45 days after submission of the application.

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

Families are req ired to report changes in New York State residency or health ins rance coverage that wo ld make a child ineligible for subsidy payments. Effective Jan ary 1, 2014, these changes m st be provided to New York State of Health if that is where enrollment originated. If enrollment originated with the health plan prior to Jan ary 1, 2014, changes m st be reported directly to the health plan. If a family submits req ired eligibility information that affects their enrollment stat s, the information will be implemented prospectively. A family may inc r a different family premi m contrib tion or enrolled in Medicaid based on the new information.

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

G idance: States may only req ire the SSN of the child who is applying for coverage. If SSNs are req ired and the State covers unborn children, indicate that the nborn children are exempt from providing aSSN. Other standards incl de, b t are not limited to pres mptive eligibility and deemed newborns.

4.1.9.1 ☒ States sho ld specify whether Social Sec rity Numbers (SSN) are req ired.

New York req ires that an applicant provide their social sec rity n mber if they have one. Applicants who are nable to obtain a social sec rity n mber d e to their immigration stat s or beca se of religio s objections may still apply for and be eligible for coverage.

G idance: States sho ld describe their contin o s eligibility process and pop lations that can be contin o sly eligible.

4.1.9.2 ☒ Contin o s eligibility

F lly eligible children are granted twelve months of contin o s eligibility with the following exceptions: the child no longer resides in New York State; the child has access to the New York State Health Ins rance Program or has obtained other health ins rance coverage; the child has enrolled in Medicaid; the child has reached the age of 19; or the applicable premi m payment has not been paid. At the State's discretion, either allow additional time for enrollees to pay o tstanding family premi m contrib tions or waive s ch contrib tions for enrollees living in and/or working in FEMA or Governor declared disaster areas at the time of the disaster event. In the event of a disaster, the State will notify CMS of the intent to provide temporary adj stments to its enrollment and/or re-determination policies, the effective dates of s ch adj stments and the co nties/areas impacted by the disaster.

4. 1-PW ☐ **Pregnant Women Option** (section 2112) The State incl des eligibility for one or more pop lations of targeted low-income pregnant women nder the plan. Describe the pop lation of pregnant women that the State proposes to cover in this section. Incl de all eligibility criteria, s ch as those described in the above categories (for instance, income and reso rces) that will be applied to this pop lation. Use the same reference n mber system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

G idance: States have the option to cover groups of "lawf lly residing" children and/or pregnant women. States may elect to cover (1) "lawf lly residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawf lly residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawf lly residing in the U.S. m st offer coverage to all s ch individ als who meet the definition of lawf lly residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, b t m st also extend the coverage option to Medicaid. States will need to update their b dget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only f nds, it is helpf l to indicate that so CMS nderstands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR ☒ **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 iss ed J ly 1, 2010) Check if the State is electing the option nder section 214 of the Children's Health Ins rance Program Rea thorization Act of 2009 (CHIPRA) regarding lawf lly residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawf lly residing in the United States incl ding the following:

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

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

(2) An alien in nonimmigrant stat s who has not violated the terms of the stat s nder which he or she was admitted or to which he or she has changed after admission;

(3) An alien who has been paroled into the United States p rs ant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosec tion, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:

(i) Aliens c rrently in temporary resident stat s p rs ant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);

(ii) Aliens c rrently nder Temporary Protected Stat s (TPS) p rs ant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment a thorization;

(iii) Aliens who have been granted employment a thorization nder 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) Family Unity beneficiaries p rs ant to section 301 of Pub. L. 101649, as amended;

(v) Aliens c rrently nder Deferred Enforced Depart re (DED) p rs ant to a decision made by the President;

(vi) Aliens c rrently in deferred action stat s; or

(vii) Aliens whose visa petition has been approved and who have a pending application for adj stment of stat s;

(5) A pending applicant for asyl m nder section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal nder section 241(b)(3) of the INA (8 U.S.C. § 1231) or nder the Convention Against Tort re who has been granted employment a thorization, and s ch an applicant nder the age of 14 who has had an application pending for at least180 days;

(6) An alien who has been granted withholding of removal nder the Convention Against Tort re;

(7) A child who has a pending application for Special Immigrant J venile stat s as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));

(8) An alien who is lawf lly present in the Commonwealth of the Northern Mariana Islands nder 48 U.S.C. § 1806(e); or

(9) An alien who is lawf lly present in American Samoa nder the immigration laws of American Samoa.

☐ Elected for pregnant women.

☒ Elected for children nder age 19.

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

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

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

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

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

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

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

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

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

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

4.3. **Methodology.** Describe the methods of establishing and contin ing eligibility and enrollment. The description sho ld address the proced res for applying the eligibility standards, the organization and infrastr ct re responsible for making and reviewing eligibility determinations, and the process for enrollment of individ als receiving covered services, and whether the State ses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

Children m st recertify ann ally. At the State's discretion, additional time may be allowed for enrollees to complete the renewal process for enrollees living in and/or working in FEMA or Governor declared disaster areas at the time of the disaster event. In the event of a disaster, the State will notify CMS of the intent to provide temporary adj stments to its enrollment and/or redetermination policies, the effective dates of s ch adj stments and the co nties/areas impacted by the disaster.

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

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

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

G idance: Note that for p rposes of pres mptive eligibility, States do not need to verify the citizenship stat s of the child. States electing this option sho ld indicate so in the State plan. (42 CFR 457.355)

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

A two- month pres mptive period of eligibility is available to children as a means of providing services nder the Child Health Pl s program when a child appears eligible for the program b t pertinent doc mentation is missing. Effective Jan ary 1, 2014, if one or more pieces of req ired doc mentation s ch as income or immigration stat s is missing b t the applicant appears eligible based on the application submitted to NY State of Health, the family is allowed upto two months to submit the doc mentation or the child is disenrolled from the program. At the State's discretion, additional time may be allowed for enrollees to supply req ired doc mentation to f lly enroll the child for enrollees living in and/or working in FEMA or Governor declared disaster areas at the time of the disaster event. In the event of a disaster, the State will notify CMS of the intent to provide temporary adj stments to its enrollment and/or redetermination policies, the effective dates of s ch adj stments and the co nties/areas impacted by the disaster.

G idance: Describe how the State intends to implement the Express Lane option. Incl de information on the identified Express Lane agency or agencies, and whether the State will be sing the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

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

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

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

4.3.3.3-EL List the components/components of CHIP eligibility that are determined nder the Express Lane. In this section, specify any differences in b dget nit, deeming, income excl sions, income disregards, or other methodology between CHIP eligibility determinations for s ch children and the determination nder the Express Lane option.

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

4.3.3.4-EL Describe the option sed to satisfy the screen and enrollment req irements before a child may be enrolled nder title XXI.

G idance: States sho ld describe the process they se to screen and enroll children req ired nder section 2102(b)(3)(A) and (B) of the Social Sec rity Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minim m of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to acco nt for any differences between the income calc lation methodologies sed by an Express Lane agency and those sed by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Incl de the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calc lated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states sho ld describe their eligibility screening process in a way that addresses the five ass rances specified below. The State sho ld consider incl ding important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make ass rances.
(Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4. Eligibility screening and coordination with other health coverage programs
States m st describe how they will ass re that:

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

Effective Jan ary 1, 2014, New York State of Health application asks if the child has any other health ins rance or Medicaid. If the child indicates he/she has other coverage, the application f rther asks for specific detail to determine if it is one of the excepted benefits as stated in 4.1.7. If it is not, the child is determined ineligible for Child Health Pl s coverage. As a f rther check, prior to enrollment, a check is performed to ens re the child does not have Medicaid or other public coverage. If this res lts in a match, the child is not enrolled in Child Health Pl s.

4.4.2. ☒ children fo nd thro gh the screening process to be potentially eligible for medical assistance nder the State Medicaid plan are enrolled for assistance nder s ch plan; (Section 2102(b)(3)(B)) (42CFR, 457.350(a)(2))

Effective Jan ary 1, 2014, New York State of Health, New York's Health Ins rance Marketplace, is an integrated eligibility system that determines eligibility for Child Health Pl s, Medicaid and Q alified Health Plans, with and witho t tax credits. The applicant applies for financial assistance, not a specific program. If, based on eligibility factors, the child is determined Medicaid eligible, he/she will be enrolled in Medicaid and not Child Health Pl s.

4.4.3. ☒ children fo nd thro gh the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

Effective Jan ary 1, 2014, New York State of Health, New York's Health Ins rance Marketplace, is an integrated eligibility system that determines eligibility for Child Health Pl s, Medicaid and Q alified Health Plans, with and witho t tax credits. The applicant applies for financial assistance, not a specific program. If, based on eligibility factors, the child is determined Child Health Pl s eligible, he/she will be enrolled in Child Health Pl s, not Medicaid.

4.4.4. ☒ the ins rance provided nder the State child health plan does not substit te for coverage nder group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)

The State monitors prior ins rance of applicants to ens re that the program does not substit te for coverage nder gro p health plans. The application on New York State of Health asks if the applicant c rrently has ins rance or if they have had coverage within the past 90 days. If they c rrently have health coverage, they are not eligible for the program. If they had health coverage, they are q estioned if it was thro gh their employer and the reason they no longer have health ins rance thro gh their employer. For children nder 250 percent of the federal poverty level, the State collects the information on prior health ins rance stat s q arterly from the health plans. This information is analyzed to determine the percentage of new enrollees who have dropped employer-based health ins rance for

enrollment in CHPl s. If the percentage reaches an average of eight (8) percent for the last three (3) q arters, a six-month waiting period will be imposed. The responsible ad lt filling o t an application m st attest to the so rce and nat re of any health care coverage the child is receiving or has received in the past six months.

Children whose gross family income is between 251% and 400% of the federal poverty level (as defined and updated by the United States Department of Health and H man Services) cannot have had a private employer-based health ins rance coverage d ring the past six months nless s ch coverage was dropped d e to the following:

(a) Loss of employment d e to factors other than vol ntary separation;
(b) Death of the family member which res lts in termination of coverage nder a group health plan nder which the child is covered;
(c) Change to a new employer that does not provide an option for comprehensive health benefits coverage;
(d) Change of residence so that no employer-based comprehensive health benefits coverage is available;
(e) Discontin ation of comprehensive health benefits coverage to all employees of the applicant's employer;
(f) Expiration of the coverage periods established by COBRA or the provisions of subsection (m) of section three tho sand two h ndred twenty-one, subsection (k) of section fo r tho sand three h ndred fo r and subsection (e) of section fo r tho sand three h ndred five of the ins rance law;
(g) Termination of comprehensive health benefits coverage d e to long term disability;
(h) The cost of employment based health ins rance is more than 5 percent of the family's income;
(i) A child applying for coverage nder these provisions is pregnant;
(j) A child applying for coverage nder this provision is at or below the age of five;
(k) Child has special health care needs;
(l) Child lost coverage as a res lt of a divorce; or
(m) The cost of family coverage incl ding the child exceeds 9.5% of ho sehold income.

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

4.4.4.1. ☐ (formerly 4.4.4.4) If the State provides coverage nder a premi m assistance program, describe: 1) the minim m period witho t coverage nder a group health plan. This sho ld incl de any allowable exceptions to the waiting period; 2) the expected minim m level of contrib tion employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))

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

Thro gh statewide CHPl s and Medicaid coverage, the provision of health ins rance to targeted low-income children in the State who are Indians as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c) is ens red. The Department also maintains an Indian Health Program which deals directly with the Native American pop lations on or near all reservations in the State. All health care providers who deal with the Native American pop lation enco rage enrollment in CHPl s. The referral process to CHPl s is incl ded in the contracts between the Department and reservation health care providers.

To f rther enhance o treach and potential enrollment of Native Americans, several IPA/Navigator grantees provide application assistance to tribes thro gho t the State. ~~This incl des a grant with the American Indian Comm nity Ho se.~~

G idance: When the State is sing an income finding from an Express Lane agency, the State m st still comply with screen and enroll req irements before enrolling children in CHIP. The State may either contin e its c rrent screen and enroll process, or elect one of two new options to f lfill these req irements.

4.4-EL The State sho ld designate the option it will be sing to carry o t screen and enroll req irements:

☐ The State will contin e to se the screen and enroll proced res req ired nder section 2102(b)(3)(A) and (B) of the Social Sec rity Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

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

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

Section 6. Coverage Requirements for Children's Health Insurance

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

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

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

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

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

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

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

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

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

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

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

- The coverage incl des benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and o tpatient hospital services,
  - physicians' services,
  - s rgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, incl ding age-appropriate imm nizations, and
  - emergency services;
- The coverage has an aggregate act arial val e that is at least act arially eq ivalent to one of the benchmark benefit packages (FEHBP-eq ivalent coverage, State employee coverage, or coverage offered thro gh an HMO coverage plan that has the largest ins red commercial enrollment in the state); and
- The coverage has an act arial val e that is eq al to at least 75 percent of the act arial val e of the additional categories in s ch package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription dr gs,
  - mental health services,
  - vision services and
  - hearing services.

If 6.1.2. is checked, a signed act arial memorand m m st be attached. The act ary who prepares the opinion m st select and specify the standardized set and pop lation to be sed nder paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State m st provide s fficient detail to explain the basis of the methodologies sed to estimate the act arial val e or, if req ested by CMS, to replicate the State res lts.

The act arial report m st be prepared by an individ al who is a member of the American Academy of Act aries. This report m st be prepared in accordance with the principles and standards of the American Academy of Act aries. In preparing the report, the act ary m st se generally accepted act arial principles and methodologies, se a standardized set of tilization and price factors, se a standardized pop lation that is representative of privately ins red children of the age of children who are expected to be covered nder the State child health plan, apply the same principles and factors in comparing the val e of different coverage (or categories of services), witho t taking into acco nt any differences in coverage based on the method of delivery or means of cost control or tilization sed, and take into acco nt the ability of a State to red ce benefits by taking into acco nt the increase in act arial val e of benefits coverage offered nder the State child health plan

that res lts from the limitations on cost sharing nder s ch coverage. (Section 2103(a)(2))

6.1.2. ☐ Benchmark-eq ivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, incl ding the amo nt, scope and d ration of each service, as well as any excl sions or limitations. Attach a signed act arial report that meets the req irements specified in 42 CFR 457.431.

G idance: A State approved nder the provision below, may modify its program from time to time so long as it contin es to provide coverage at least eq al to the lower of the act arial val e of the coverage nder the program as of A g st 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an act arial opinion doc menting that the act arial val e of the modification is greater than the val e as of A g st 5, 1997, or one of the benchmark plans m st be attached. Also, the fiscal year 1996 State expendit res for "existing comprehensive state-based coverage" m st be described in the space provided for all states. (Section 2103(a)(3))

6.1.3. ☒ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an act arial opinion doc menting that the act arial val e of the modification is greater than the val e as of A g st 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expendit res for existing comprehensive state-based coverage.

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

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

6.1.4.1. ☐ Coverage the same as Medicaid State plan

6.1.4.2. ☐ Comprehensive coverage for children nder a Medicaid Section 1115 demonstration waiver

6.1.4.3. ☐ Coverage that either incl des the f ll EPSDT benefit or that the State has extended to the entire Medicaid pop lation

G idance: Check below if the coverage offered incl des benchmark coverage, as specified in 457.420, pl s additional coverage. Under this option, the State m st clearly demonstrate that the coverage it provides incl des the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☐ Coverage that incl des benchmark coverage pl s additional coverage

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

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

G idance: Check below if the State is p rchasing coverage thro gh a group health plan, and intends to demonstrate that the group health plan is substantially eq ivalent to or greater than to coverage nder one of the benchmark plans specified in 457.420, thro gh se of abenefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be sed. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit nder the benchmark, the State m st provide an act arial analysis as described in 457.431 to determine act arial eq ivalence.

6.1.4.6. ☐ Coverage nder a group health plan that is substantially eq ivalent to or greater than benchmark coverage thro gh a benefit by benefit comparison (Provide a sample of how the comparison will be done)

G idance: Check below if the State elects to provide a so rce of coverage that is not described above. Describe the coverage that will be offered, incl ding any benefit limitations or excl sions.

6.1.4.7. ☐ Other (Describe)

G idance: All forms of coverage that the State elects to provide to children in its plan m st be checked. The State sho ld also describe the scope, amo nt and d ration of services covered nder its plan, as well as any excl sions or limitations. States that choose to cover nborn children nder the State plan sho ld incl de a separate section 6.2 that specifies benefits for the nborn child pop lation. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, b t chooses to provide a different benefit package for these pregnant women nder the CHIP plan, the state m st incl de a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

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

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

- **Inpatient Hospital Medical or Surgical Care**

Scope of Coverage: Inpatient hospital medical or s rgical care will be considered a covered benefit for a registered bed patient for treatment

of an illness, inj ry or condition which cannot be treated on an o tpatient basis. The hospital m st be a short-term, ac te care facility and New York State licensed.

Level of Coverage: Incl des 365 days per year coverage for inpatient hospital services and services provided by physicians and other professional personnel for covered inpatient services; bed and board, incl ding special diet and n tritional therapy; general, special and critical care n rsing service, b t not private d ty n rsing services; facilities, services, supplies and eq ipment related to s rgical operations, recovery facilities, anesthesia, and facilities for intensive or special care; oxygen and other inhalation therape tic services and supplies; dr gs and medications that are not experimental; sera, biologicals, vaccines, intraveno s preparations, dressings, casts, and materials for diagnostic st dies; blood prod cts, except when participation in a vol nteer blood replacement program is available to the ins red or covered person, and services and eq ipment related to their administration; facilities, services, supplies and eq ipment related to physical medicine and occupational therapy and rehabilitation; facilities, services, supplies and eq ipment related to diagnostic st dies and the monitoring of physiologic f nctions, incl ding b t not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electro-encephalographic st dies and examinations; facilities, services, supplies and eq ipment related to radiation and n clear therapy; facilities, services, supplies and eq ipment related to emergency medical care; chemotherapy; any additional medical, s rgical, or related services, supplies and eq ipment that are c stomarily f rnished by the hospital. No benefits will be provided for any o t-of-hospital days, or if inpatient care was not necessary; no benefits are provided after discharge; benefits are paid in f ll for accommodations in a semi-private room.

6.2.2. ☒ O tpatient services (Section 2110(a)(2))

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

Scope of Coverage: Provides services on amb latory basis by a covered provider for medically necessary diagnosis and treatment of sickness and inj ry and other conditions incl ding the screening, diagnosis and treatment of a tism spectr m disorders. An A tism spectr m disorder means any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical man al of mental disorders, incl ding a tistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder or pervasive developmental disorder not otherwise specified. All

services related to o tpatient visits are covered, incl ding physician services.

Level of Coverage: No limitations. Incl des wo nd dressing and casts to immobilize fract res for the immediate treatment of the medical condition. Injections and medications provided at the time of the office visit or therapy will be covered. Incl des a diometric testing where deemed medically necessary.

- **Outpatient Surgery**

Scope of Coverage: Proced res performed within the provider's office will be covered as well as "amb latory s rgery proced res" which may be performed in a hospital-based amb latory s rgery service or a freestanding amb latory s rgery center.
Level o Coverage: The utilization review process will ensure that the ambulatory surgery is appropriately provided.

- **Emergency Medical Services**

Scope of Coverage: For services to treat an emergency condition in hospital facilities. For the p rpose of this provision, "emergency condition" means a medical or behavioral condition, the onset of which is s dden, that manifests itself by symptoms of s fficient severity, incl ding severe pain, that a pr dent layperson, possessing an average knowledge of medicine and health, co ld reasonably expect the absence of immediate medical attention to res lt in (A) placing the health of the person afflicted with s ch condition in serio s jeopardy, or in the case of a behavioral condition placing the health of s ch person or others in serio s jeopardy; (B) serio s impairment to s ch person's bodily f nctions; (C) serio s dysf nction of any bodily organ or part of s ch person; or (D) serio s disfig rement of s ch person.
Level of Coverage: No limitations.

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

- **Pediatric Health Promotion visits.**

Scope of Coverage: Well child care visits in accordance with a visitation sched le established by American Academy of Pediatrics and the Childhood Imm nization Sched le of the United States will be followed for imm nizations.

Level of Coverage: Incl des all services related to visits. Incl des imm nizations, well child care, health ed cation, tuberc lin tests

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

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

See Section 6.2.2.

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

See Section 6.2.2.

6.2.4. ☒ S rgical services (Section 2110(a)(4))

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

- **Pre-surgical testing**

Scope of Coverage: All tests, (laboratory, x-ray, etc) necessary prior to inpatient or o tpatient s rgery.

Level of Coverage: Benefits are available if a physician orders the tests; proper diagnosis and treatment req ire the tests; and the s rgery takes place within 7 days after the testing. If s rgery is cancelled beca se of pre-s rgical test findings or as a res lt of a second opinion on s rgery, the cost of the tests will be covered.

6.2.5. ☒ Clinic services (incl ding health center services) and other amb latory health care services. (Section 2110(a)(5))

See Section 6.2.2 In accordance with section 503 of the Children's Health Ins rance Program Rea thorization Act of 2009 (CHIPRA), federally-q alified health centers and r ral health clinics (f rther referred to as FQHCs) will be reimb rsed sing an alternative payment methodology for all services provided on or after October 1, 2009.

The Department will be calc lating monthly supplemental payments tilizing the Medicaid prospective payment system (PPS) rates of payment to FQHCs and information provided by the FQHC. Supplemental payments to the FQHC will be made to the FQHC thro gh the participating CHPl s managed care organizations (MCO).

Supplemental payments will be made for only claims paid and/or approved by the MCOs and/or their subcontracted Independent Practice Associations (IPAs).

In order to q alify for and receive supplemental payments for services provided to CHPl s enrollees, each FQHC m st have approved PPS rates in effect for the time period and site where services were provided to a MCO enrollee; have an exec ted contract with the MCO, or an IPA that contracts with the MCO, for the time period; and m st have received, in the aggregate, MCO payments for services rendered that are less than the FQHC wo ld have received for those same services nder the appropriate PPS Medicaid rates.

FQHCs are req ired to bill MCOs for all enco nters for which a supplemental payment is being req ested. MCOs will make payments on those claims based on their c rrent contract or approve those claims in cases where a capitated arrangement exists between both parties. This information m st be maintained and reported to the Department to ens re that the State is only making payment for an approved service that was properly billed.
Based on the information reported to the Department from the FQHC, the Department will calc late the supplemental payment that is d e to each FQHC for each MCO. This "supplemental payment" is the aggregate difference between what that FQHC is paid thro gh contracts with MCOs and its specific Medicaid PPS rate acc m lated for each month.

The total supplemental payments d e to FQHCs will be added to the appropriate MCO's monthly vo cher for their CHPl s enrollees. The MCO will pay the FQHC the supplemental payment no later than the end of the month they receive payment on their vo cher.
The Department will compare information received from the FQHCs to the enco nter data submitted by the MCOs, reconcile any material differences and adj st the supplemental payments accordingly.

The Department plans to implement an initiative to incentivize the development of patient-centered medical homes for the CHPl s program. The medical home initiative is based upon the standards developed by the National Committee for Q ality Ass rance's (NCQA) for the Physician Practice Connections – Patient-Centered Medical Home Program (PPC-PCMH). The PPC-PCMH is a model of care that seeks to strengthen the physician-patient relationship by promoting improved access, coordinated care, and enhanced patient/family engagement. Office-based practitioners (physicians and registered n rse practitioners) and Article 28 clinics that are approved

as a medical homes and recognized by the NCQA as meeting the req irements of the PPC-PCMH program, will receive an additional payment for primary care services provided to CHPl s enrollees. Additionally, a subset of providers classified as medical homes came together to establish the Adirondack Medical Home Multipayer Demonstration Program. This Program was established to improve health care o tcomes and efficiency thro gh patient contin ity and coordination of services. They will receive an additional payment for providing primary care services that differs from the medical home initiative describe above. The additional payment will be incl ded in the per-member per-month all-incl sive premi m paid to each MCO. The MCO is responsible for reimb rsing the medical home. This initiative is expected to begin on October 1, 2011.

6.2.6. ☒ Prescription dr gs (Section 2110(a)(6))

Scope of Coverage: Prescription medications m st be a thorized by a professional licensed to write prescriptions.

Level of Coverage: Prescriptions m st be medically necessary. May be limited to generic medications where medically acceptable. Incl des family planning or contraceptive medications or devices. All medications sed for preventive and therape tic p rposes will be covered, incl ding prescription dr gs needed to treat an a tism spectr m disorder. Vitamin coverage need not be mandated except when necessary to treat a diagnosed illness or condition.

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

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

Level of Coverage: All medications sed for preventive and therape tic p rposes a thorized by a professional licensed to write prescriptions will be covered.

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

- **Diagnostic and Laboratory Tests**

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

Level of Coverage: No limitations.

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

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

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

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

- **Prenatal Care**

See Section 6.2.28.

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

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

Level of coverage: No limitations.

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

- **Outpatient visits for mental health**

Scope of Coverage: Services must be provided by certified and/or licensed professionals. Effective April 1, 2016, reimbursement for ambulatory behavioral health services provided by Article 28 (DOH), Article 31 (OMH) and Article 32 (OASAS) providers must be paid at least the equivalent of the Ambulatory Patient Group (APG) rate.

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

6.2.12. ☒ D rable medical eq ipment and other medically-related or remedial devices (s ch as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

- **Durable Medical Equipment (DME)**

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

  Level of Coverage: DME not limited except there is no coverage for cranial prostheses (i.e. wigs) and dental prostheses, except those made necessary d e to accidental inj ry to so nd, nat ral teeth and provided within twelve months of the accident, and except for dental prostheses needed in treatment of a congenital abnormality or as part of reconstr ctive s rgery. 2110(a)(13)) Incl des coverage of assistive comm nication devices for children with a tism spectr m disorder, who are nable to comm nicate thro gh normal means s ch as speech or in writing, for coverage of dedicated comm nication devices s ch as comm nication boards and speech-generating devices which are p rchased or rented. Health plans are not responsible for covering items s ch as laptops, desktops, or tablet comp ters b t are responsible for covering software and/or applications that enable a laptop, desktop, or tablet comp ter to f nction as a speech-generating device.

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

G idance: Home and comm nity based services may incl de supportive services s ch as home health n rsing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

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

  Scope of Coverage: Ins lin, blood gl cose monitors, blood gl cose monitors for legally blind, data management systems, test strips for monitors and vis al reading, rine test strips, insulin injection aids, cartridges for legally blind, syringes, ins lin p mps and app rtenances thereto, ins lin inf sion devices, oral agents.

  Level of Coverage: As prescribed by a physician or other licensed health care provider legally a thorized to prescribe nder Title 8 of the Ed cation Law.

- **Ostomy Supplies and equipment**

Scope of Coverage: Supplies and eq ipment sed to contain diverted rine or fecal contents o tside the body from a s rgically created opening (stoma).

Level of Coverage: As prescribed by a health care provider legally a thorized to prescribe nder Title 8 of the Ed cation Law.

6.2.14. ☒ Home and comm nity-based health care services (Section 2110(a)(14))
G idance: Nursing services may incl de n rse practitioner services, n rse midwife services, advanced practice n rse services, private d ty n rsing care, pediatric n rse services, and respiratory care services in a home, school or other setting.

- **Home Health Care Services**

Scope of Coverage: The care and treatment of a covered person who is nder the care of a physician b t only if hospitalization or confinement in a skilled n rsing facility wo ld have been otherwise req ired if home care was not provided, the service is approved in writing by s ch physician, and the plan covering the home health service is established by the Department.

Level of Coverage: Home care shall be provided by a certified home health agency possessing a valid certificate of approval iss ed p rs ant to Article 36 of the Public Health Law. Home care shall consist of one or more of the following: part-time or intermittent home n rsing care by or nder the supervision of a registered professional n rse (R.N.); part-time or intermittent home health aide services which consist primarily of caring for the patient; physical, occupational or speech therapy if provided by the home health agency; medical supplies, dr gs and medications prescribed by a physician; and laboratory services by or on behalf of a certified home health agency to the extent s ch items wo ld have been covered or provided if the covered person had been hospitalized or confined in a skilled n rsing facility. A minim m of forty s ch visits m st be provided in any calendar year.

- **Diabetic Education and Home Visits**

Scope of Coverage: Diabetes self-management ed cation (incl ding diet); reed cation or refresher. Home visits for diabetic monitoring and/or ed cation.

Level of Coverage: Limited to medically necessary visits where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management or where reed cation is necessary. May be provided by a physician or other licensed health care provider legally a thorized to prescribe nder Title 8 of the Ed cation Law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes n rse ed cator, certified n tritionist, certified dietitian or registered dietitian upon the referral of a physician or other licensed health care provider legally a thorized to prescribe nder Title 8 of the Ed cation Law and shall be limited to group settings wherever practicable.

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

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

Scope of Coverage: The federally f nded portion of the CHPl s program will not be sed to cover abortions except in the case of rape, incest or to save the life of the mother.

Level of Coverage: No limitations.

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

Scope of Coverage: Emergency, preventive and ro tine dental services.

Level of Coverage: No limitations.

6.2.18. ☒ Inpatient substance ab se treatment services and residential substance ab se treatment services (Section 2110(a)(18))

Scope of coverage: Services provided in a facility operated by the Office of Mental Health nder Section 7.17 of the Mental Hygiene Law, or a facility iss ed an operating certificate p rs ant to Article 23 or Article 31 of the Mental Hygiene Law or a general hospital as defined in Article 28 of the Public Health Law.

Level of coverage: No limitations.

6.2.19. ☒ O tpatient substance ab se treatment services (Section 2110(a)(19))

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

Level of coverage: No limitations.

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

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

6.2.22. ☒ Physical therapy, occupational therapy, and services for individ als with speech, hearing, and lang age disorders (Section 2110(a)(22))

- **Speech Therapy**

Scope of coverage: Speech therapies performed by an a diologist, lang age pathologist, a speech therapist and/or otolaryngologist.

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

- **Hearing**

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

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

- **Physical and Occupational Therapy**

Scope of coverage: Short-term physical and occ pational therapies.

Level of coverage: These therapies m st be medically necessary and nder the supervision or referral of a licensed physician. Short-term physical and occupational therapies will be covered when ordered by a physician. Physical and occupational therapies for a child diagnosed

with an a tism spectr m disorder are also covered when s ch treatment is deemed habilitative or nonrestorative.

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

G idance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therape tic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or f rnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed nder the general supervision or at the direction of a physician; or 3) f rnished by a health care facility that is operated by a State or local government or is licensed nder State law and operating within the scope of the license.

- **Hospice**

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

  Level of Coverage: Hospice services incl de palliative and supportive care provided to a patient to meet the special needs arising o t of physical, psychological, spirit al, social and economic stress which are experienced d ring the final stages of illness and d ring dying and bereavement. In accordance with Section 2302 of the Affordable Care Act, children are allowed to receive hospice services witho t forgoing any medically necessary c rative services incl ded in the Child Health Pl s benefit package. Hospice organizations m st be certified nder Article 40 of the NYS Public Health Law. All services m st be provided by q alified employees and vol nteers of the hospice or by q alified staff thro gh contract al arrangements to the extent permitted by federal and state req irements. All services m st be provided according to a written plan of care which reflects the changing needs of the patient/family. Family members are eligible for p to five visits for bereavement co nseling (bereavement co nseling not f nded thro gh program).

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

- **Therapeutic Services**

  Scope of Coverage: Amb latory radiation therapy and chemotherapy. Injections and medications provided at time of therapy (i.e.,

chemotherapy) will also be covered. Hemodialysis will be a covered service. Short term physical and occupational therapies will be covered when ordered by aphysician. Inf sion of blood clotting factor and other services in connection with the treatment of blood clotting protein deficiencies.

Level of Coverage: No limitations. These therapies m st be medically necessary and nder the supervision or referral of a licensed physician. No experimental proced res or services will be reimb rsed. Determination of the need for hemodialysis services and whether home based or facility based treatment is appropriate will be made by a licensed physician. Coverage for blood clotting factor, supplies and other services needed for home inf sion of blood clotting factor for the treatment of a blood clotting protein deficiency. Inf sion may be performed in an o tpatient setting or in the home by ahome health care agency, a properly trained parent of legal g ardian of a child or a properly trained child that is physically and developmentally capable of self-administering s ch prod cts.

6.2.25. ☐ Premi ms for private health care ins rance coverage (Section 2110(a)(25))

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

G idance: Enabling services, s ch as transportation, translation, and o treach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individ als.

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

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

Level of Coverage: Services m st be provided by an amb lance service iss ed a certificate to operate p rs ant to section 3005 of the Public Health Law. Eval ation and treatment services m st be for an emergency condition defined as a medical or behavioral condition, the onset of which is s dden, that manifests itself by symptoms of s fficient severity, incl ding severe pain, that a pr dent layperson, possessing an average knowledge of medicine and health, co ld reasonably expect the absence of immediate medical attention to res lt in (i) placing the health of the person afflicted with s ch condition in

serio s jeopardy; (ii) serio s impairment to s ch person's bodily f nctions; (iii) serio s dysf nction of any bodily organ or part of s ch person; or (iv) serio s disfig rement of s ch person.

6.2.27. ☐ Enabling services (s ch as transportation, translation, and o treach services) (Section 2110(a)(27))

6.2.28. ☒ Any other health care services or items specified by the Secretary and not incl ded nder this Section (Section 2110(a)(28))

- **Maternity Care**

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

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

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

6.2.1-DC ☒ State Specific Dental Benefit Package. The State ass res dental services represented by the following categories of common dental terminology (CDT[1]) codes are incl ded in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (m st follow periodicity sched le)

2. Preventive (i.e., dental prophylaxis, topical fl oride treatments, sealants) (CDT codes: D1000-D1999) (m st follow periodicity sched le)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of g m disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dent res) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial S rgery (i.e., extractions of teeth and other oral s rgical proced res) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.1-DC Periodicity Sched le. The State has adopted the following periodicity sched le:

☐ State-developed Medicaid-specific
☐ American Academy of Pediatric Dentistry
☐ Other Nationally recognized periodicity sched le
☒ Other (description attached)

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

6.2.2.1-DC ☐ FEHBP-eq ivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[2] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

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

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

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

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

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

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

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

G idance: States may req est two additional p rchase options in Title XXI: cost effective coverage thro gh a comm nity-based health delivery system and for the p rchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

6. . **Additional Purchase Options-** If the State wishes to provide services nder the plan thro gh cost effective alternatives or the p rchase of family coverage, it m st req est the appropriate option. To be approved, the State m st address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ **Cost Effective Coverage-** Payment may be made to a State in excess of the 10 percent limitation on se of f nds for payments for: 1) other child health assistance for targeted low-income children; 2) expendit res for health services initiatives nder the plan for improving the health of children (incl ding targeted low-income children and other low-income children); 3) expendit res for o treach activities as provided in Section 2102(c)(1) nder the plan; and 4) other reasonable costs inc rred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children thro gh s ch expendit res m st meet the coverage req irements above; Describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

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

G idance: Check below if the State is req esting toprovide cost-effective coverage thro gh a comm nity-based health delivery system. This allows the State to waive the 10 percent limitation on expendit res not sed for Medicaid or health ins rance assistance if coverage provided to targeted low-income children thro gh s ch expendit res meets the req irements of Section 2103; the cost of s ch coverage is not greater, on an average per child basis, than the cost of coverage that wo ld otherwise be provided nder Section 2103; and s ch coverage is provided thro gh the se of a comm nity-based health delivery system, s ch as thro gh contracts with health centers receiving f nds nder Section 330 of the Public Health Services Act or with hospitals s ch as those that receive disproportionate share payment adj stments nder Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is req ested, the State m st demonstrate that payments in excess of the 10 percent limitation will be sed for other child health assistance for targeted low-income children; expendit res for health services initiatives nder the plan for improving the health of children (incl ding targeted low-income children and other low-income children); expendit res for o treach activities as provided in Section 2102(c)(1) nder the plan; and other reasonable costs inc rred by the State to administer the plan. (42CFR, 457.1005(a))

6.4.1.3. The coverage m st be provided thro gh the se of a comm nity based health delivery system, s ch as thro gh contracts with health centers receiving f nds nder Section 330 of the Public Health Service Act or with hospitals s ch as those that receive disproportionate share payment adj stments nder Section 1886(c)(5)(F) or 1923 of the Social Sec rity Act. Describe the comm nity-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2. ☐ **Purchase of Family Coverage**- Describe the plan to p rchase family coverage. Payment may be made to a State for the p rpose of family coverage nder a group health plan or health ins rance coverage that incl des coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

G idance: Check 6.4.2.if the State is req esting top rchase family coverage. Any State req esting to p rchase s ch coverage will need to incl de information that establishes to the Secretary's satisfaction that: 1) when compared to the amo nt of money that wo ld have been paid to cover only the children

involved with a comparable package, the p rchase of family coverage is cost effective; and 2) the p rchase of family coverage is not a substit tion for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. P rchase of family coverage is cost-effective. The State's cost of p rchasing family coverage, incl ding administrative expendit res, that incl des coverage for the targeted low-income children involved or the family involved (as applicable) nder premi m assistance programs m st not be greater than the cost of obtaining coverage nder the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, incl ding administrative costs, for children or families nder premi m assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premi m assisted coverage in the aggregate.

6.4.2.2. The State ass res that the family coverage wo ld not otherwise substit te for health ins rance coverage that wo ld be provided to s ch children b t for the p rchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The State ass res that the coverage for the family otherwise meets title XXI req irements. (42CFR 457.1010(c))

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 iss ed Febr ary, 2, 2010) A State may elect to offer a premi m assistance subsidy for q alified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance nder the plan and have access to s ch coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) nless the child vol ntarily elects to receive s ch a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

☐ Yes
☒ No

6.4.3.1-PA Q alified Employer-Sponsored Coverage and Premi m Assistance Subsidy

6.4.3.1.1-PA Provide an ass rance that the q alified employer-sponsored ins rance meets the definition of q alified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premi m assistance subsidy meets the definition of premi m assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premi m assistance subsidy as reimb rsement to an employee or for o t-of-pocket expendit res or directly to the employee's employer.

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

6.4.3.2.1-PA If the State is providing premi m assistance for q alified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an ass rance that the State is providing for each targeted low-income child enrolled in s ch coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, nder the q alified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided thro gh the employer or by the State providing wraparo nd benefits.

6.4.3.2.3-PA If the State is providing premi m assistance for benchmark or benchmark-eq ivalent coverage, the State ens res that s ch group health plans or health ins rance coverage offered thro gh an employer will be certified by an act ary as coverage that is eq ivalent to a benchmark benefit package described in Section 2103(b) or benchmark eq ivalent coverage that meets the req irements of Section 2103(a)(2).

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

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

6.4.3.4-PA: Opt-O t and O treach, Ed cation, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ens ring parents are permitted to disenroll their child from q alified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for s ch assistance and in a manner that ens res contin ity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State's o treach, ed cation, and enrollment efforts related to premi m assistance programs, as req ired nder Section 2102(c)(3).

How does the State inform families of the availability of premi m assistance, and assist them in obtaining s ch subsidies? What are the specific significant reso rces the State intends to apply to ed cate employers abo t the availability of premi m assistance subsidies nder the State child health plan? (Section 2102(c))

6.4.3.5-PA **Purchasing Pool**- A State may establish an employer-family premi m assistance p rchasing pool and may provide a premi m assistance subsidy for enrollment in coverage made available thro gh this pool (Section 2105(c)(10)(I)). Does the State provide this option?

☐ Yes
☒ No

6.6.3.5.1-PA Describe the plan to establish an employer-family premi m assistance p rchasing pool.

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

6.6.3.5.3-PA Provide an ass rance that the State will not claim for any administrative expendit res attrib table to the establishment or operation of s ch a pool except to the extent s ch payment wo ld otherwise be permitted nder this title.

6.4.3.6-PA **Notice of Availability of Premium Assistance**- Describe the proced res that ass re that if a State provides premi m assistance subsidies nder this Section, it m st: 1) provide as part of the application and enrollment process, information describing the availability of premi m assistance and how to elect to obtain a subsidy; and 2) establish other proced res to ens re that parents are f lly informed of the choices for child health assistance or thro gh the receipt of premi m assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an ass rance that the State incl des information abo t premi m assistance on the CHIP application or enrollment form.

CHIP Budget

STATE: New York	**FFY Budget 2015-16 Actuals**	**FFY Budget 2016-17 Projected**	**FFY Budget 2017-18 Projected**
State's enhanced FMAP rate	**88%**	**88%**	**88%**
Benefit Costs			
Ins rance payments	$729,108,770	$758,273,120	$781,021,314
Managed care	$504,883,426	$525,078,763	$540,831,126
per member/per month rate			
Fee for Service			
Total Benefit Costs	**$1,233,992,196**	**$1,283,351,883**	**$1,321,852,440**
(Offsetting beneficiary cost sharing payments)	($56,800,000)	($56,800,000)	($56,800,000)
Net Benefit Costs	**$1,177,192,196**	**$1,226,551,883**	**$1,265,052,440**
Cost of Proposed SPA Changes – Benefit			
Administration Costs			
General administration	$19,000,000	$25,000,000	$25,000,000
Contractors/Brokers			
Claims Processing			
O treach/marketing costs		$100,000	$100,000
Health Services Initiatives		$1,250,000	$14,400,000
Other			
Total Administration Costs	**$19,000,000**	**$26,350,000**	**$39,400,000**
Federal Share	$1,052,649,132	$1,102,553,657	$1,148,006,147
State Share	$143,543,064	$150,348,226	$156,446,293
Total Costs of Approved CHIP Plan	**$1,196,192,196**	**$1,252,901,883**	**$1,304,452,440**

Note:

The Health Services Initiative line incl des projections for the Sickle Cell and Poison Control programs which were approved in SPA NY-16-022-C-A. It also incl des projections for Lead, HPNAP and Opioid programs which are being submitted in this SPA.