

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The template includes the following sections:

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

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

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

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

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

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

Medicaid Expansion- CHIP SPA Requirements

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

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

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

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

Medicaid Expansion- Medicaid SPA Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Original Plan

Original Submission

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

SPA #1

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

SPA #2

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

SPA #3

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

SPA #4

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

SPA #5 (compliance)

Submission date:	March 31, 2003
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SPA #6 (renewal process)

Submission date: March 22, 2004
Effective date: April 1, 2003
Implementation date: April 1, 2003

SPA #7

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

SPA #8

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

SPA #9

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

SPA # 10

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

SPA # 11

Submission date: May 14, 2007
Effective date: September 1, 2007
Implementation date: September 1, 2007

SPA # 12

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

SPA # 13	
Submission date:	June 30, 2009
Effective date:	April 1, 2009
Implementation date:	April 1, 2009
SPA # 14	
Submission date:	July 6, 2009
Effective date:	July 1, 2009
Implementation date:	July 1, 2009
SPA # 15	
Submission date:	March 29, 2010
Effective date:	April 1, 2009
Implementation date:	April 1, 2009
SPA # 16	
Submission date:	March 21, 2011
Effective date:	April 1, 2010
Implementation date:	April 1, 2010
SPA # 17	
Submission date:	May 20, 2011
Effective date (Enrollment Center):	June 13, 2011
Effective date (Medical Homes Initiative):	October 1, 2011
Implementation date:	June 13, 2011
SPA # 18	
Submission date:	September 20, 2011
Effective date:	August 25, 2011
Implementation date:	August 25, 2011
SPA # 19	
Submission date:	March 22, 2012
Effective date (Medicaid Expansion):	November 11, 2011
Implementation date:	November 11, 2011
SPA # 20	
Submission date:	March 31, 2014
Effective date (autism benefit):	April 1, 2013
Effective date (other ACA changes)	January 1, 2014
Implementation date:	April 1, 2013 and January 1, 2014

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

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

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

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

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

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

SPA #NY- 21-0031-CHIP
Submission Date: March 31, 2022
Effective Date Ends Manual Process
to Remove Children from the Child
Health Plus Waiting period and replaces CS 20
attachment: July 15, 2021
Implementation Date: July 15, 2021

SPA #NY- 21-0032-CHIP

Submission Date:	March 31, 2022
Effective Date: Compliance with the American Rescue Plan Act of 2021:	March 11, 2021
Implementation Date:	March 11, 2021

SPA #NY-22-0033-CHIP

Submission Date:	September 15, 2022
Effective Date: Elimination of the \$9 Family Premium Contribution:	October 1, 2022
Implementation Date:	October 1, 2022

SPA #NY-23-0034-CHIP *Pending Submission*

Submission Date: Unborn Child Option	March X, 2023
Effective Date: Coverage:	April 1, 2022
Implementation Date:	April 1, 2022

SPA #NY-23-0035-CHIP

Submission Date:	March XX, 2023
Effective Date: Benefit Expansion:	January 1, 2023
Implementation Date:	January 1, 2023

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

			Presumptive Eligibility for Children	
NY-19-0025	Non-Financial Eligibility	CS20	Substitution of Coverage	Supersedes the previously approved CS20.
Effective/Implementation Date: April 1, 2018				

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

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

TN No: Approval Date Effective Date

Section 6. Coverage Requirements for Children's Health Insurance

- 6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)
Please see Appendix I, New York State Child Health Plus Benefits Package, for further details regarding the scope and level of coverage of each benefit listed below.

- 6.2.2. Disposable medical supplies (Section 2110(a)(13))

- **Diabetic Supplies and equipment**

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

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

- **Ostomy Supplies and equipment**

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

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

- **Medical Supplies**

Scope of Coverage: Medical Supplies means items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment or orthopedic footwear which have been ordered by a practitioner in the treatment of a specific medical condition and which are usually consumable, nonreusable, disposable, for a specific purpose and generally have no salvageable value.

Level of Coverage:

Medical supplies coverage examples include, but are not limited to:

- Diabetic Supplies
- Enteral Formulas and Supplies
- Wound dressings and disposable care accessories
- Airway clearance device filters
- Disposable collection and storage bag for breast milk

A fiscal order for medical supplies may be refilled when the prescriber has indicated on the order the number of refills and the member has requested the refill.

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

• **Core Limited Health Related Services**

Scope of Coverage:

Services include the five Core Limited Health-Related Services listed below:

1. Skill Building (provided by Licensed Behavioral Health Practitioners (LBHPs) as described in Article 29-I VFCA Health Facilities License Guidelines and any subsequent updates)
2. Nursing Services
3. Treatment Planning and Discharge Planning
4. Clinical Consultation/Supervision Services
5. VFCA Child Health Plus Liaison/Administrator

Level of Coverage:

Health/behavioral health care services must meet reasonable and acceptable standards of health practice as determined by the State in consultation with recognized health organizations.

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

- 6.2.5. Medical transportation (Section 2110(a)(26))

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

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

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

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

Transportation Between Hospitals:

When a Child Health Plus enrollee is admitted to a hospital licensed under Article 28 of the Public Health Law, the reimbursement paid to the hospital includes all necessary transportation services for the inpatient. If the admitting hospital sends an inpatient round trip to another hospital for the purposes of obtaining a diagnostic test or therapeutic service, the original admitting hospital is responsible for the provision of the transportation services.

•Air Ambulance Services

Scope of Coverage: Fixed wing air ambulance services and rotary wing air ambulance service.

Level of Coverage:

Air ambulance transportation must meet the following criteria:

- The patient has a catastrophic, life-threatening illness or condition;
- The patient is at a hospital that is unable to properly manage the medical condition;
- The patient needs to be transported to a uniquely qualified hospital facility and ground transport is not appropriate for the patient;
- Rapid transport is necessary to minimize risk of death or deterioration of the patient's condition; or
- Life-support equipment and advanced medical care is necessary during transport.

6.3.2- BH Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

6.3.2.1- BH Psychosocial treatment

Provided for: Mental Health Substance Use Disorder

- Assertive Community Treatment Services (ACT), Young Adult ACT and Youth ACT**

Scope of Coverage: Coverage includes comprehensive and integrated combination of treatment, rehabilitation, case management, and support services primarily provided in the client's residence or other community locations by a mobile, multi-disciplinary mental health treatment team.

Level of Coverage: Services support individual recovery through an assertive, person-centered approach that assists individuals to cope with the symptoms of their mental illness or serious emotional disturbance and reacquire the skills necessary to function and remain integrated in the community.

6.3.2.4- BH Peer Support
Provided for: Mental Health Substance Use Disorder

• **Youth Peer Support (YPS):**

Scope of Coverage: Youth Peer Support (YPS) services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services.

Level of Coverage: Youth Peer Support activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth's individualized treatment plan.

6.3.2.5- BH Caregiver Support
Provided for: Mental Health Substance Use Disorder

• **Family Peer Support Services (FPSS):**

Scope of Coverage: Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community.

Level of Coverage: Services are delivered in a trauma informed, culturally and linguistically competent manner. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's treatment plan.

6.3.2.8- BH Intensive outpatient
Provided for: Mental Health Substance Use Disorder

• **Children and Family Treatment and Support Services: Community Psychiatric Supports and Treatment (CPST):**

Scope of Coverage: Services that are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in the child/youth's treatment plan.

Level of Coverage: Services include the following components: Rehabilitative Psychoeducation, Intensive Interventions, Strengths Based Treatment Planning, Rehabilitative Supports, Crisis Avoidance, and Intermediate Term Crisis Management.

6.3.2.9- BH Psychosocial rehabilitation
Provided for: Mental Health Substance Use Disorder

• **Psychosocial Rehabilitation (PSR):**

Scope of Coverage: Services are designed for children/youth and their families/caregivers to assist with implementing interventions outlined in the treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with a child/youth's behavioral health needs.

Level of Coverage: Includes services for restoration, rehabilitation, and support for a child/youth's functional level as necessary for the integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional interventions.

6.3.5.1- BH Crisis Intervention and Stabilization
Provided for: Mental Health Substance Use Disorder

• **Children and Family Treatment and Support Services: Outpatient and Residential Crisis Intervention (CI):**

Scope of Coverage: Services for children/youth who are identified as experiencing an acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g., collateral, provider, community member) to effectively resolve it.

Level of Coverage: Includes services for engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future.

6.3.9- BH Other

Provided for: Mental Health Substance Use Disorder

• **Children and Family Treatment and Support Services: Other Licensed Practitioner (OLP):**

Scope of Coverage: Services performed by a non-physician behavioral health practitioner for treatment necessary to address the prevention (to encourage and increase protective factors and healthy behaviors that can help prevent the onset of a diagnosable behavioral health disorder and reduce risk factors that can lead to the development of a behavioral health disorder), diagnosis, and/or treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain, or regain functional capacity.

Level of Coverage: Includes services delivered by a Non-Physician Licensed Behavioral Health Practitioner (NP-LBHP) who is licensed in the state of New York operating within the scope of practice defined in State law and in any setting permissible under State practice law.

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

6.2.1-DC State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT¹) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)

2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)

Scope of Coverage: Preventive Dental Care

Level of Coverage: Topical fluoride treatment: when professionally administered in accordance with appropriate standards.

3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)

Scope of Coverage: Orthodontics for severe physically handicapping malocclusions

Level of Coverage:

With the exception of D8210 (Removable appliance therapy), D8220 (Fixed appliance therapy) and D8999 (Unspecified orthodontic procedure, by report), orthodontic care is reimbursable only when provided by an orthodontist or an Article 28 facility which have met the qualifications of the DOH and are enrolled with the appropriate specialty code. Prior approval for orthodontia coverage is required.

Additional scope of coverage guidance can be found in the Handicapping Labio-Lingual Deviation (HLD) Index Report.

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

- Planned use of funds, including:
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
 - Assumptions on which the budget is based, including cost per child and expected enrollment.
 - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional

- coverage of the unborn, lawfully residing eligibles, dental services, etc.
- All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
 - Total 1-year cost of adding prenatal coverage
 - Estimate of unborn children covered in year 1

CHILD HEALTH PLUS BUDGET SUMMARY

	<i>Actual</i>	<i>Projected</i>	<i>Projected</i>
	2021-22	2022-23	2023-24
Benefit Costs			
Insurance Payments	\$911,643,937	\$926,234,983	\$967,915,557
Managed Care Payments	\$926,033,582	\$967,705,093	\$1,011,251,822
Fee for Service			
Total Benefit Costs	\$1,837,677,518	\$1,893,940,076	\$1,979,167,379
<i>(Offsetting beneficiary cost sharing payments)</i>	(\$60,553,536)	(\$44,112,000)	(\$44,112,000)
Net Benefit Costs	\$1,777,123,982	\$1,849,828,076	\$1,935,055,379

1/1/2023 Benefit Expansion Cost	\$0	\$67,292,240	\$92,424,404
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Net Benefit Costs Plus Benefit Expansion Cost	\$1,777,123,982	\$1,917,120,316	\$2,027,479,783
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	2021-22 Actual	2022-23 Projected	2023-24 Projected
Administration Costs			
Personnel	\$1,724,444	\$1,776,177	\$1,829,462
General Administration	\$38,098,163	\$48,872,509	\$56,210,446
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs	\$4,161,331	\$4,286,171	\$4,414,756
Other (e.g., indirect costs)	\$1,164,616	\$1,199,555	\$1,235,541
Health Services Initiatives	\$152,309,667	\$156,878,957	\$161,585,326
Total Administration Costs	\$197,458,220	\$213,013,368	\$225,275,531
10% Administrative Cap	\$197,458,220	\$213,013,368	\$225,275,531

Federal Title XXI Share	\$1,369,175,299	\$1,458,768,800	\$1,470,204,437
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State Share	\$605,406,903	\$671,364,884	\$782,550,877
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TOTAL COSTS OF APPROVED CHIP PLAN	\$1,974,582,203	\$2,130,133,684	\$2,252,755,315
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Appendix I

New York State Child Health Plus Benefits Package

Child Health Plus Benefits Package

No Pre-Existing Condition Limitations Permitted

No Co-payments or Deductibles

Effective January 1, 2023

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

General Coverage	Scope of Coverage	Level of Coverage
Maternity Care	Inpatient hospital coverage for at least 48 hours after childbirth for any delivery other than a C-Section and in at least 96 hours following a C-section. Also coverage of parent education, assistance and training in breast and bottle feeding and any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the 48/96 hours, provided that at least one home care visit is covered post-discharge. Prenatal, labor and delivery is covered.	No limitations; (however subsidized children requiring maternity care services will be referred to Medicaid).
Inpatient Mental Health and Alcohol and Substance Abuse Services	Services to be provided in a facility operated by OMH under sec. 7.17 of the Mental Hygiene Law, or a facility issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law or a general hospital as defined in Article 28 of the Public Health Law.	No limitations for inpatient mental health services, inpatient detoxification and inpatient rehabilitation.

General Coverage	Scope of Coverage	Level of Coverage
<p><u>Assertive Community Treatment Services (ACT), Young Adult ACT and Youth ACT</u></p>	<p>Coverage includes comprehensive and integrated combination of treatment, rehabilitation, case management, and support services primarily provided in the client's residence or other community locations by a mobile, multi-disciplinary mental health treatment team.</p>	<p>Services support individual recovery through an assertive, person-centered approach that assists individuals to cope with the symptoms of their mental illness or serious emotional disturbance and reacquire the skills necessary to function and remain integrated in the community. ACT Services are intended to benefit individuals with serious behavioral health challenges and a treatment history that includes psychiatric hospitalization and emergency room visits, involvement with the criminal justice system, alcohol or substance abuse, homelessness, at risk of, or history of institutional level of care or residential placement or lack of engagement in traditional outpatient services.</p> <p>Services must be referred by a physician or other licensed practitioner of the healing arts, within their scope of practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level. A full list of provider types covered under licensed practitioner of the healing arts can be found in Attachment 3.1-A of the New York Medicaid State Plan under Assertive Community Treatment in section 13.d Rehabilitative Services, or page five on the link below: https://www.health.ny.gov/regulations/state_plans/status/non-inst/approved/docs/app_2022-04-11_spa_21-15.pdf</p> <p>Coverage of ACT services is not covered if the child does not meet the criteria described below:</p> <ul style="list-style-type: none"> (i) meet the definition of persons with serious mental illness as set forth in section 1.03 of the Mental Hygiene Law; (ii) have been referred or approved by the Single Point of Access entity for enrollment in ACT services; and (iii) are active clients of the ACT provider. <p>No limitations.</p> <p>Services shall be reimbursed in accordance with government rate-setting methodology.</p>
<p>NOTE: Refer to the Office of Mental Health ACT Program Guidelines found here https://omh.ny.gov/omhweb/act/act_program_guidelines_2007_collateral.pdf for a more detailed description of services.</p>		
<p>Inpatient Rehabilitation</p>	<p>Acute care services provided by an Article 28 General Hospital</p>	<p>Services supplies and equipment related to physical medicine and occupational therapy and short-term rehabilitation.</p>
<p>Professional Services for Diagnosis and Treatment of Illness and Injury</p>	<p>Provides services on ambulatory basis by a covered provider for medically necessary diagnosis and treatment of sickness and injury and other conditions. Includes all services related to visits. Professional services are provided on outpatient basis and inpatient basis.</p>	<p>No limitations. Includes wound dressing and casts to immobilize fractures for the immediate treatment of the medical condition. Injections and medications provided at the time of the office visit or therapy will be covered. Includes audiometric testing where deemed medically necessary.</p>

General Coverage	Scope of Coverage	Level of Coverage						
Hospice Services and Expenses	Coordinated hospice program of home and inpatient services which provide non-curative medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six months or less.	Hospice services include palliative and supportive care provided to a patient to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement. Hospice organizations must be certified under Article 40 of the NYS Public Health Law. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by federal and state requirements. All services must be provided according to a written plan of care which reflects the changing needs of the patient/family. Family members are eligible for up to five visits for bereavement counseling.						
Outpatient Surgery	Procedure performed within the provider's office will be covered as well as "ambulatory surgery procedures" which may be performed in a hospital-based ambulatory surgery service or a freestanding ambulatory surgery center.	The utilization review process must ensure that the ambulatory surgery is appropriately provided.						
Diagnostic and Laboratory Tests	Prescribed ambulatory clinical laboratory tests and diagnostic x-rays.	No limitations.						
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	<p>Durable Medical Equipment means devices and equipment ordered by a practitioner for the treatment of a specific medical condition which:</p> <ul style="list-style-type: none"> ☐ Can withstand repeated use for a protracted period of time; ☐ Are primarily and customarily used for medical purposes; ☐ Are generally not useful in the absence of illness or injury; and ☐ Are usually not fitted, designed or fashioned for a particular person's use. <p>DME intended for use by one person may be custom-made or customized.</p>	<p>Includes hospital beds and accessories, oxygen and oxygen supplies, pressure pads, volume ventilators, therapeutic ventilators, nebulizers and other equipment for respiratory care, traction equipment, walkers, wheelchairs and accessories, commode chairs, toilet rails, apnea monitors, patient lifts, nutrition infusion pumps, ambulatory infusion pumps and other miscellaneous DME.</p> <p>DME coverage includes equipment servicing (labor and parts). Examples include, but are not limited to:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Fitted/Customized leg brace</td> <td style="width: 50%;">Not fitted/Customized cane</td> </tr> <tr> <td>Prosthetic arm</td> <td>Wheelchair</td> </tr> <tr> <td>Footplate</td> <td>Crutches</td> </tr> </table>	Fitted/Customized leg brace	Not fitted/Customized cane	Prosthetic arm	Wheelchair	Footplate	Crutches
	Fitted/Customized leg brace	Not fitted/Customized cane						
	Prosthetic arm	Wheelchair						
Footplate	Crutches							
Prosthetic Appliances are those appliances and devices ordered by a qualified practitioner which replace any missing part of the body.	Covered without limitation except that there is no coverage for cranial prosthesis (<i>i.e.</i> wigs) and dental prosthesis, except those made necessary due to accidental injury to sound, natural teeth and provided within twelve months of the accident, and except for dental prosthesis needed in treatment of congenital abnormality or as part of reconstructive surgery							
Orthotic Devices are those devices which are used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body	No limitations on orthotic devices except that, devices prescribed solely for use during sports are not covered.							

General Coverage	Scope of Coverage	Level of Coverage
Medical Supplies	<p><u>Medical Supplies means items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment or orthopedic footwear which have been ordered by a practitioner in the treatment of a specific medical condition and which are usually consumable, nonreusable, disposable, for a specific purpose and generally have no salvageable value.</u></p>	<p>Medical supplies coverage examples include, but are not limited to:</p> <ul style="list-style-type: none"> • <u>Diabetic Supplies</u> • <u>Enteral Formulas and Supplies</u> • <u>Wound dressings and disposable care accessories</u> • <u>Airway clearance device filters</u> • <u>Disposable collection and storage bag for breast milk</u> <p><u>A fiscal order for medical supplies may be refilled when the prescriber has indicated on the order the number of refills and the member has requested the refill. All refills must be appropriately referenced to the original order by the dispenser.</u></p>
	Diabetic Supplies and Equipment	<p>Insulin, blood glucose monitors, blood glucose monitors for visually impaired, data management systems, test strips for monitors and visual reading, urine test strips, insulin, injection aids, cartridges for visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, oral agents.</p> <p>As prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law.</p>
	Ostomy Equipment and Supplies	<p>Ostomy equipment and supplies used to contain diverted urine or fecal contents outside the body from a surgically created opening (stoma).</p> <p>As prescribed by a health care provider legally authorized to prescribe under title eight of the education law.</p>
	<p>NOTE: Refer to New York State Medicaid Program Procedure Code Manual for a more detailed description of covered services. https://www.emedny.org/ProviderManuals/DME/PDFS/DME_Procedure_Codes.pdf</p>	
Therapeutic Services	Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (<i>i.e.</i> chemotherapy) will also be covered.	No limitations. These therapies must be medically necessary and under the supervision or referral of a licensed physician. Short term physical and occupational therapies will be covered when ordered by a physician. Physical and occupational therapies for a child diagnosed with an autism spectrum disorder are also covered when such treatment is deemed habilitative or nonrestorative. No procedure or services considered experimental will be reimbursed.
	Hemodialysis	Determination of the need for services and whether home-based or facility-based treatment is appropriate.
	Infusion of blood clotting factor and other services in connection with the treatment of blood clotting protein deficiencies	Coverage for blood clotting factor, supplies and other services needed for home infusion of blood clotting factor for the treatment of a blood clotting protein deficiency. Infusion may be performed in an outpatient setting or in the home by a home health care agency, a properly trained parent or legal guardian of a child, or a properly trained child that is physically and developmentally capable of self-administering such products.

General Coverage	Scope of Coverage	Level of Coverage
Speech and Hearing Services Including Hearing Aids	Hearing examinations to determine the need for corrective action and speech therapy performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist.	One hearing examination per calendar year is covered. If an auditory deficiency requires additional hearing exams and follow-up exams, these exams will be covered. Hearing aids, including batteries and repairs, are covered. If medically necessary, more than one hearing aid will be covered. Covered speech therapy services are those required for a condition amenable to significant clinical improvement within a two-month period, beginning with the first day of therapy. Covered speech therapy services for a child diagnosed with an autism spectrum disorder shall also be provided if deemed habilitative or nonrestorative.
Pre-Surgical Testing	All tests (laboratory, x-ray, etc.) necessary prior to inpatient or outpatient surgery.	Benefits are available if a physician orders the tests: proper diagnosis and treatment require the tests; and the surgery takes place within seven days after the testing. If surgery is canceled because of pre-surgical test findings or as a result of a Second Opinion on Surgery, the cost of the tests will be covered.
Second Surgical Opinion	Provided by a qualified physician.	No limitations.
Second Medical Opinion	Provided by an appropriate specialist, including one affiliated with a specialty care center.	A second medical opinion is available in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation of a course of treatment of cancer.
Outpatient Visits for Mental Health and for the Diagnosis and Treatment of Alcoholism and Substance Abuse	Services must be provided by certified and/or licensed professionals.	No limitations. Visits may include family therapy for alcohol, drug and/or mental health as long as such therapy is directly related to the enrolled child's alcohol, drug and/or mental health treatment.
Home Health Care Services	The care and treatment of a covered person who is under the care of a physician but only if hospitalization or confinement in a skilled nursing facility would otherwise have been required if home care was not provided and the plan covering the home health service is established and provided in writing by such physician.	Home care shall be provided by a certified home health agency possessing a valid certificate of approval issued pursuant to Article 36 of the Public Health Law. Home care shall consist of one or more of the following: part-time or intermittent home health aide services which consist primarily of caring for the patient, physical, occupational, or speech therapy if provided by the home health agency and medical supplies, drugs and medications prescribed by a physician, and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered or provided under the contract if the covered person had been hospitalized or confined in a skilled nursing facility. The contract must provide 40 such visits in any calendar year, if such visits are medically necessary.
Diabetic Education and Home Visits	Diabetes self-management education (including diet); reeducation or refresher. Home visits for diabetic monitoring and/or education.	Limited to visits medically necessary where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management or where reeducation is necessary. May be provided by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified diagnosis nutritionist, certified dietician or registered dietician upon the referral of a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law and may be limited to group settings wherever practicable.

General Coverage	Scope of Coverage	Level of Coverage
Prescription and Non-Prescription Drugs	Prescription and non-prescription medications must be authorized by a professional licensed to write prescriptions.	Prescriptions must be medically necessary. May be limited to generic medications where medically acceptable. Includes family planning or contraceptive medications or devices. All medications used for preventive and therapeutic purposes will be covered. Vitamins are not covered except when necessary to treat a diagnosed illness or condition. Coverage includes enteral formulas for home use for which a physician or other provider authorized to prescribe has issued a written order. Enteral formulas for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein. Coverage for such modified solid food products shall not exceed \$2500 per calendar year.
Emergency Medical Services	For services to treat an emergency condition in hospital facilities. For the purpose of this provision, "emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: <ul style="list-style-type: none"> ▣ Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; ▣ Serious impairment to such person's bodily functions; ▣ Serious dysfunction of any bodily organ or part of such person; or ▣ Serious disfigurement of such person. 	No limitations.

General Coverage	Scope of Coverage	Level of Coverage
<p>Ambulance Services</p>	<p>Pre-hospital emergency medical services, including prompt evaluation and treatment of an emergency condition and/or non-airborne transportation to a hospital.</p>	<p>Services must be provided by an ambulance service issued a certificate to operate pursuant to Section 3005 of the Public Health Law.</p> <p>Evaluation and treatment services must be for an emergency condition defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:</p> <ul style="list-style-type: none"> ⇒ Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; ⇒ Serious impairment to such person's bodily functions; ⇒ Serious dysfunction of any bodily organ or part of such person; or ⇒ Serious disfigurement of such person. <p><i>Coverage for non-airborne emergency transportation is based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonable expect the absence of such transportation to result in:</i></p> <ul style="list-style-type: none"> ⇒ Placing the health of the person afflicted with such condition in serious jeopardy; ⇒ Serious impairment to such person's bodily functions; ⇒ Serious dysfunction of any bodily organ or part of such person; or ⇒ Serious disfigurement of such person. <p><u>Transportation Between Hospitals:</u></p> <p><u>When a Child Health Plus enrollee is admitted to a hospital licensed under Article 28 of the Public Health Law, the reimbursement paid to the hospital includes all necessary transportation services for the inpatient. If the admitting hospital sends an inpatient round trip to another hospital for the purposes of obtaining a diagnostic test or therapeutic service, the original admitting hospital is responsible for the provision of the transportation services.</u></p> <p><u>The following ambulance transports are considered emergency transports; therefore, prior authorization is not required:</u></p> <ul style="list-style-type: none"> - <u>Transport from an Emergency Room to a Psychiatric Center</u> - <u>Transport from an Emergency Room to a Trauma/Cardiac Care/Burn Center.</u> - <u>Transportation from an Emergency Room to an Emergency Room.</u> - <u>Transportation from an Emergency Room to Another Facility.</u>

General Coverage	Scope of Coverage	Level of Coverage
<u>Air Ambulance Services</u>	Fixed wing air ambulance services and rotary wing air ambulance services	<p>Air ambulance transportation must meet the following criteria:</p> <ul style="list-style-type: none"> • <u>The patient has a catastrophic, life-threatening illness or condition;</u> • <u>The patient is at a hospital that is unable to properly manage the medical condition;</u> • <u>The patient needs to be transported to a uniquely qualified hospital facility and ground transport is not appropriate for the patient;</u> • <u>Rapid transport is necessary to minimize risk of death or deterioration of the patient's condition; or</u> • <u>Life-support equipment and advanced medical care is necessary during transport.</u> <p><u>The following fixed wing air ambulance services are reimbursable when the transport physically occurs:</u></p> <ul style="list-style-type: none"> • <u>Base Fee (lift-off/call-out);</u> • <u>Patient loaded mileage;</u> • <u>Physician (when ordered by hospital);</u> • <u>Respiratory therapist (when ordered by the hospital, and only when the hospital is unable to supply); or</u> • <u>Destination ground ambulance charge (only when the destination is out of state).</u> <p><u>The following helicopter (rotary wing) air ambulance services are reimbursable:</u></p> <ul style="list-style-type: none"> • <u>Lift off from base; or</u> • <u>Patient occupied flight mileage.</u>
<p>NOTE: Refer to the New York State Medicaid Program Transportation Manual Policy Guidelines for a more detailed description of services. https://www.emedny.org/ProviderManuals/Transportation/PDFS/Transportation_Manual_Policy_Section.pdf</p>		

General Coverage	Scope of Coverage	Level of Coverage
Emergency, Preventive and Routine Vision Care	Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.	The vision examination may include, but is not limited to: <ul style="list-style-type: none"> ⇒ Case history ⇒ Internal and External examination of the eye ⇒ Ophthalmoscopic exam ⇒ Determination of refractive status ⇒ Binocular balance ⇒ Tonometry tests for glaucoma ⇒ Gross visual fields and color vision testing ⇒ Summary findings and recommendations for corrective lenses
	Prescribed Lenses	At a minimum, quality standard prescription lenses provided by a physician, optometrist or optician are to be covered once in any twelve month period, unless required more frequently with appropriate documentation. The lenses may be glass or plastic lenses.
	Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve month period, unless required more frequently with appropriate documentation. If medically warranted, more than one pair of glasses will be covered.
	Contact Lenses	Covered when medically necessary.
Emergency, Preventive and Routine Dental Care	Emergency Dental Care	Includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.

General Coverage	Scope of Coverage	Level of Coverage
	Preventive Dental Care	<p>Includes procedures which help prevent oral disease from occurring, including but not limited to:</p> <ul style="list-style-type: none"> ☰ Prophylaxis: scaling and polishing the teeth at 6-month intervals. ☰ <u>Topical fluoride treatment: when professionally administered in accordance with appropriate standards. Services must be provided by:</u> <ul style="list-style-type: none"> • <u>Physicians and nurse practitioners for members 0 through 6 years of age.</u> • <u>Dentists and dental hygienists (under general supervision of the dentist) in the dental office through age 19.</u> <ul style="list-style-type: none"> • <u>Fluoride varnish is reimbursable to physicians and nurse practitioners once per three (3) month intervals under CPT code 99188 (application of topical fluoride varnish by a physician or other qualified health care professional).</u> • <u>For dentists and dental hygienists, benefit is limited to gel, foam, and varnish and must be a minimum interval of three (3) months between all fluoride treatments under CDT codes D1206 (Professionally applied fluoride varnish) and/or D1208 (Topical application of fluoride excluding varnish).</u> <p><u>Fluoride treatments that are not reimbursable under the program include:</u></p> <ul style="list-style-type: none"> • <u>Treatment that incorporates fluoride with prophylaxis paste;</u> • <u>Topical application of fluoride to the prepared portion of a tooth prior to</u> • <u>restoration;</u> • <u>Fluoride rinse or "swish"; and,</u> • <u>Treatment for desensitization</u> <ul style="list-style-type: none"> ☰ Sealants on unrestored permanent molar teeth. ☰ Space Maintenance: unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
	Routine Dental Care	<ul style="list-style-type: none"> ☰ Dental examinations, visits and consultations covered once within 6 month consecutive period (when primary teeth erupt) ☰ X-ray, full mouth x-rays at 36 month intervals, if necessary, bitewing x-rays at 6-12 month intervals, or panoramic x-rays at 36 month intervals if necessary; and other x-rays as required (once primary teeth erupt) ☰ All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization including preoperative care and postoperative care ☰ In office conscious sedation ☰ Amalgam, composite restorations and stainless steel crowns ☰ Other restorative materials appropriate for children
	Endodontics	Includes all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.

General Coverage	Scope of Coverage	Level of Coverage
	Prosthodontics	<p>Removable: Complete or partial dentures including six months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.</p> <p>Fixed: Fixed bridges are not covered unless</p> <ol style="list-style-type: none"> 1) Required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth; 2) Required for cleft-palate treatment or stabilization; 3) Required, as demonstrated by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis.
	<p><u>Orthodontics for severe physically handicapping malocclusions</u></p>	<p>Prior approval for orthodontia coverage is required. Includes procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias. Services include orthodontic care for severe physically handicapping malocclusions as a once in a lifetime benefit that will be reimbursed for an eligible member for a maximum of three years of active orthodontic care, plus one year of retention care. Retreatment for relapsed cases is not a covered service. Treatment must be approved and active therapy begun (appliances placed and activated) prior to the member's 19th birthday.</p> <p>Orthodontia coverage is not covered if the child does not meet the criteria described above. Procedures include but are not limited to:</p> <ul style="list-style-type: none"> ⇒ Rapid Palatal Expansion (RPE) ⇒ Placement of component parts (e.g. brackets, bands) ⇒ Interceptive orthodontic treatment ⇒ Comprehensive orthodontic treatment (during which orthodontic appliances have been placed for active treatment and periodically adjusted) ⇒ Removable appliance therapy ⇒ Orthodontic retention (removal of appliances, construction and placement of retainers) <p><u>With the exception of D8210 (Removable appliance therapy), D8220 (Fixed appliance therapy) and D8999 (Unspecified orthodontic procedure, by report), orthodontic care is reimbursable only when provided by an orthodontist or an Article 28 facility which have met the qualifications of the DOH and are enrolled with the appropriate specialty code.</u></p> <p>NOTE: Refer to the New York State Medicaid Dental Policy and Procedure Code manual for a more detailed description of services.</p>

General Coverage	Scope of Coverage	Level of Coverage
<p><u>Children and Family Treatment and Support Services (CFTSS):</u> <u>Other Licensed Practitioner (OLP)</u></p>	<p><u>Services performed by a non-physician behavioral health practitioner for treatment necessary to address the prevention (to encourage and increase protective factors and healthy behaviors that can help prevent the onset of a diagnosable behavioral health disorder and reduce risk factors that can lead to the development of a behavioral health disorder), diagnosis, and/or treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain, or regain functional capacity.</u></p> <p><u>An assessment of needs may result in the recommendation of further medically necessary services, such as rehabilitative services. Services are delivered in a trauma informed, culturally and linguistically competent manner.</u></p>	<p><u>Includes services delivered by a Non-Physician Licensed Behavioral Health Practitioner (NP-LBHP) who is licensed in the state of New York operating within the scope of practice defined in State law and in any setting permissible under State practice law. The clinical services provided under OLP are intended to help prevent the progression of behavioral health needs through early identification and intervention and may be provided to children/youth in need of assessment for whom behavioral health conditions have not yet been diagnosed. Services are also intended to provide treatment for children/youth with an existing diagnosis for whom flexible community-based treatment is needed to correct or ameliorate conditions identified during an assessment process, such as problems in functioning or capacity for healthy relationships.</u></p> <p><u>Limits/Exclusions:</u></p> <ul style="list-style-type: none"> • <u>Group limit refers to number of participants, regardless of payor. Groups should not exceed eight. Consideration may be given to smaller limit of members if participants are younger than eight years of age. Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator.</u> • <u>Groups may include family/collaterals, as long as the contact is directly related to the child/youth's treatment plan goals, for the benefit of the child/youth.</u> • <u>Inpatient hospital facilities are allowed for licensed professional other than social workers if a Preadmission Screening and Resident Review (PASRR) indicates it is medically necessary treatment. Social worker visits are included in the Nursing Facility Visits and may not be billed separately.</u> • <u>Visits to Intermediate Care Facilities for individuals with Mental Retardation (ICF-MR) are not covered.</u> • <u>All NP-LBHP services provided while the person is a resident of an institution for Mental Disease, such a free-standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not otherwise reimbursable by Child Health Plus.</u> • <u>If a child requires medically necessary services that are best delivered in the school setting by a community provider, the service needs to be detailed on the treatment plan.</u> • <u>If a child needs assistance in the schools (educationally necessary) and a school employee will be providing the service, the service must be on the child's Individualized Education Plan (IEP) (504 plan services are not reimbursable by Child Health Plus).</u> • <u>Evidence based practices (EBP) require approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State. Treatment services must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.</u> <p><u>Services shall be reimbursed in accordance with government rate-setting methodology.</u></p>

General Coverage	Scope of Coverage	Level of Coverage
<p><u>Children and Family Treatment and Support Services (CFTSS): Outpatient and Residential Crisis Intervention (C)</u></p>	<p><u>Services for children/youth who are identified as experiencing an acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g., collateral, provider, community member) to effectively resolve it. A child/youth in crisis may be referred by a family member or other collateral contact who has knowledge of the child/youth's capabilities and functioning.</u></p>	<p><u>Includes services for engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future. Crisis Intervention includes five modalities: Mobile Crisis, Crisis Stabilization, Children's Crisis Residence, Residential Crisis Support and Intensive Residential Crisis.</u></p> <p><u>Limits/Exclusions:</u></p> <ul style="list-style-type: none"> • <u>The following activities are excluded: financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature.</u> • <u>Services may not be primarily educational, vocational, recreational, or custodial (i.e., for the purpose of assisting in the activities of daily living such as bathing, dressing, eating, and maintaining personal hygiene and safety; for maintaining the recipient's or anyone else's safety, and could be provided by persons without professional skills or training). Services also do not include services, supplies or procedures performed in a nonconventional setting including: resorts, spas, therapeutic programs, and camps.</u> • <u>The child/youth's chart must reflect resolution of the crisis which marks the end of the episode. Warm handoff to follow up services with a developed plan should follow. Substance Use should be recognized and addressed in an integrated fashion as it may add to the risk and increase the need for engagement in care. Crisis services cannot be denied based upon substance use. Crisis Team members should be trained on screening for substance use disorders.</u> <p><u>Services shall be reimbursed in accordance with government rate-setting methodology.</u></p>

General Coverage	Scope of Coverage	Level of Coverage
<p><u>Children and Family Treatment and Support Services (CFTSS): Community Psychiatric Supports and Treatment (CPST)</u></p>	<p><u>Services that are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in the child/youth's treatment plan. This includes the implementation of interventions using evidenced-based techniques, drawn from cognitive-behavioral therapy and/or other evidenced-based psychotherapeutic interventions approved by New York State.</u></p>	<p><u>Services include the following components: Rehabilitative Psychoeducation, Intensive Interventions, Strengths Based Treatment Planning, Rehabilitative Supports, Crisis Avoidance, and Intermediate Term Crisis Management. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings but can benefit from community based rehabilitative services. CPST allows for delivery of services within a variety of permissible settings including community locations where the member lives, works, attends school, engages in services (e.g., provider office sites), and/or socializes.</u></p> <p><u>Limits/Exclusions:</u></p> <ul style="list-style-type: none"> • <u>The provider agency will assess the child prior to developing a treatment plan for the child.</u> • <u>Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.</u> • <u>A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.</u> • <u>Groups may be delivered under Rehabilitative Supports and Rehabilitative Psychoeducation</u> • <u>Group limit refers to number of participants, regardless of payor. Groups cannot exceed eight.</u> • <u>Consideration should be given to smaller limit of members if participants are younger than eight years of age.</u> • <u>Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator</u> • <u>Groups may include family/collaterals, with or without the child present, as long as the contact is directly related to the child/youth's goals and treatment plan</u> • <u>Evidence-Based Practices (EBP) require prior approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State The Institute of Medicine (IOM) defines 'evidence-based practice' as a combination of the following three factors:</u> <ol style="list-style-type: none"> 1. <u>best research evidence,</u> 2. <u>best clinical experience, and</u> 3. <u>consistent with patient values (IOM, 2001).</u> <p><u>Implemented interventions using evidence-based techniques may ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation</u></p> <p><u>Services shall be reimbursed in accordance with government rate-setting methodology.</u></p>

General Coverage	Scope of Coverage	Level of Coverage
<p><u>Children and Family Treatment and Support Services (CFTSS): Psychosocial Rehabilitation (PSR)</u></p>	<p><u>Services are designed for children/youth and their families/caregivers to assist with implementing interventions outlined in the treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with a child/youth’s behavioral health needs.</u></p>	<p><u>Includes services for restoration, rehabilitation, and support for a child/youth’s functional level as necessary for the integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional interventions. PSR activities are focused on addressing the rehabilitative needs of the child/youth as part of a treatment plan and can be provided in coordination with treatment interventions by a licensed practitioner (e.g., OLP) or provider of CPST. Services are delivered in a trauma informed, culturally and linguistically competent manner.</u></p> <p><u>Limits/Exclusions:</u></p> <ul style="list-style-type: none"> • <u>The provider agency will assess the child prior to developing a treatment plan for the child with the PSR worker implementing the intervention identified on the treatment plan.</u> • <u>A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.</u> • <u>Group limit refers to number of child/youth participants, regardless of payor. Groups cannot exceed eight children/youth.</u> • <u>Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator</u> • <u>Groups may include family/collaterals, with the child present, as long as the contact is directly related to the child/youth’s goals and treatment plan</u> • <u>Treatment services must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visit</u> <p><u>Services shall be reimbursed in accordance with government rate-setting methodology.</u></p>

General Coverage	Scope of Coverage	Level of Coverage
<p><u>Children and Family Treatment and Support Services (CFTSS): Family Peer Support Services (FPSS)</u></p>	<p><u>Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community.</u></p>	<p><u>Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community. Services are delivered in a trauma informed, culturally and linguistically competent manner. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth’s treatment plan.</u></p> <p><u>Limits/Exclusions:</u></p> <ul style="list-style-type: none"> • <u>The provider agency will assess the child prior to developing the treatment plan for the child.</u> • <u>Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.</u> • <u>A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.</u> • <u>A group cannot exceed more than 12 individuals in total.</u> <p><u>Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator.</u></p> <p><u>Services shall be reimbursed in accordance with government rate-setting methodology.</u></p>

General Coverage	Scope of Coverage	Level of Coverage
<p><u>Children and Family Treatment and Support Services (CFTSS): Youth Peer Support (YPS)</u></p>	<p><u>Youth Peer Support (YPS) services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills.</u></p>	<p><u>Youth Peer Support activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth’s individualized treatment plan. The structured, scheduled activities provided by this service emphasize the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting their personal, individualized life goals, develop self-advocacy skills, and to support their transition into adulthood.</u></p> <p><u>Limits/Exclusions:</u></p> <ul style="list-style-type: none"> • <u>The provider agency will assess the child prior to developing the treatment plan for the child.</u> • <u>Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.</u> • <u>A youth with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.</u> • <u>Group limit refers to number of child/youth participants, regardless of payor. Groups cannot exceed eight children/youth.</u> <p><u>Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator.</u></p> <p><u>Services shall be reimbursed in accordance with government rate-setting methodology.</u></p>
<p><u>NOTE: Refer to the New York State Children’s Behavioral Health Transition to Managed Care website for additional information on covered services and billing guidance: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/index.htm</u></p>		

General Coverage	Scope of Coverage	Level of Coverage
<p><u>29-I Health Facility Core Limited Health-Related Services</u></p>	<p>Services include the five Core Limited Health-Related Services listed below:</p> <ol style="list-style-type: none"> 1. <u>Skill Building (provided by Licensed Behavioral Health Practitioners (LBHPs) as described in Article 29-I VFCA Health Facilities License Guidelines and any subsequent updates)</u> 2. <u>Nursing Services</u> 3. <u>Treatment Planning and Discharge Planning</u> 4. <u>Clinical Consultation/Supervision Services</u> 5. <u>VFCA Child Health Plus Liaison/Administrator</u> 	<p>The child's/youth's health/behavioral health record, treatment plan, service plan and/or plan of care must reflect that the services provided:</p> <ul style="list-style-type: none"> • <u>were medically necessary and appropriate, and</u> • <u>were rendered by qualified practitioners within their scope of practice (including supervision requirements), as defined in applicable State Law</u> <p>Health/behavioral health care services must meet reasonable and acceptable standards of health practice as determined by the State in consultation with recognized health organizations. These standards include:</p> <ul style="list-style-type: none"> • <u>State-mandated licensure requirements any other State-mandated certification and programmatic requirements that impact:</u> <ul style="list-style-type: none"> o <u>the types of providers that can deliver the services;</u> o <u>the specific nature of the services; and</u> o <u>the programmatic framework within which the services can be delivered, including supervision requirements.</u> <p>Services shall be reimbursed in accordance with government rate-setting methodology.</p> <p>NOTE: Refer to the New York Medicaid Program 29-I Health Facility Billing Guidance for a more detailed description of covered services and billing guidance https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm</p>
<p>Diagnosis and Treatment of an Autism Spectrum Disorder</p>	<p>Coverage for the Screening, Diagnosis and Treatment of Autism Spectrum Disorders</p>	<p>Includes the following care and assistive communicative devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist:</p> <ul style="list-style-type: none"> ☐ Behavioral health treatment; ☐ Psychiatric care; ☐ Psychological care; ☐ Medical care provided by a licensed health care provider; ☐ Therapeutic care, including therapeutic care which is deemed habilitative or non-restorative; and ☐ Pharmacy care. <p>Applied behavioral analysis shall be covered. Assistive communication devices shall be covered when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means such as speech or in writing. Assistive communication devices such as communication boards and speech-generating devices may be rented or purchased, subject to prior approval. Coverage must include dedicated communication devices, which are devices that generally are not useful to a person in the absence of a communication impairment. Items such as laptops, desktops, or tablet computers are not covered items but software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device is a covered item.</p>

Child Health Plus Benefits Package Exclusions
Effective January 1, 2023

The following services will NOT be covered:

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