

December 14, 2015

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

Dear Ms. Edwards:

Pursuant to Title XXI of the Social Security Act, enclosed for your approval is the response for additional information regarding New York's Children's Health Insurance Program (CHIP) state plan amendment (SPA) # 20 regarding the coverage of screening, diagnosis and treatment of children with autism spectrum disorders. The SPA also makes updates in relation to implementation of the Affordable Care Act.

As discussed, an updated budget was not included as the cost of adding this benefit was determined to be minimal.

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

Sincerely,

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

Enclosure

December 14, 2015

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

Dear Mr. Melendez:

Pursuant to Title XXI of the Social Security Act, enclosed for your approval is the response for additional information regarding New York's Children's Health Insurance Program (CHIP) state plan amendment (SPA) # 20 regarding the coverage of screening, diagnosis and treatment of children with autism spectrum disorders. The SPA also makes updates in relation to implementation of the Affordable Care Act.

As discussed, an updated budget was not included in this SPA as the cost of adding this benefit was determined to be minimal.

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Sincerely,

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

Enclosure

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

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

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

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

/s/ Judith Arnold
(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: Judith Arnold	Position/Title: CHIP Director Director, Division of Eligibility and Marketplace Integration
Name: Gabrielle Armenia	Position/Title: Director, Bureau of Child Health Plus Policy and Exchange Consumer Assistance
Name:	Position/Title:

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

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 105-33 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 of 2010 further modified the program.

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:

- o 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.
- o 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)
- o Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- o Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment 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.

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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 a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan 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)); (42CFR, 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:

- o **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.

- o **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)

- o **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.

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

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Date:

Approval Date:

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

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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

Effective Date:

Implementation Date:

SPA # _____, Purpose of SPA _____

Proposed effective date:

Proposed implementation date:

Original Submission

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

SPA #1

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

SPA #2

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

SPA #3

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

SPA #4

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

SPA #5 (compliance)
 Submission date: March 31, 2003

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

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

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

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

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

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

SPA # 12

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

SPA # 13

Submission date: June 30, 2009
Effective date: April 1, 2009
Implementation date: April 1, 2009

SPA # 14

Submission date: July 6, 2009
Effective date: July 1, 2009
Implementation date: July 1, 2009

SPA # 15

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

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

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	Eligibility – Targeted Low Income Children	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3
		CS15	MAGI-Based Income Methodologies	Incorporate within a separate subsection 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	CS17	Residency	Supersedes the current section 4.1.5
		CS18	Citizenship	Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR
		CS19	Social Security Number	Supersedes the current section 4.1.9.1
		CS20	Substitution of Coverage	Supersedes the current section 4.4.4
	General Eligibility	CS21	Non-Payment of Premiums	Supersedes the current section 8.7
		CS27	Continuous Eligibility	Supersedes the current section 4.1.8
		CS28	Presumptive Eligibility for Children	Supersedes the current section 4.3.2

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.

TN No: Approval Date Effective Date _____

Section 4. Eligibility Standards and Methodology

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

4.0. Medicaid Expansion

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

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

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

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

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

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

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

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

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

4.1.3.1-PC 0% of the FPL (and not eligible for Medicaid) through 400%

of the FPL (SHO #02-004, issued November 12, 2002)

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

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

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

A child must be a resident of New York State.

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

4.1.7 Access to or coverage under other health coverage:

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

4.1.8 Duration of eligibility, not to exceed 12 months:

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

dates of such adjustments and the counties/areas impacted by the disaster.

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

Families are required to report changes in New York State residency or health insurance coverage that would make a child ineligible for subsidy payments. Effective January 1, 2014, these changes must be provided to New York State of Health if that is where enrollment originated. If enrollment originated with the health plan prior to January 1, 2014, changes must be reported directly to the health plan. If a family submits required eligibility information that affects their enrollment status, the information will be implemented prospectively. A family may incur a different family premium contribution or enrolled in Medicaid based on the new information.

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

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

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

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

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

- 4.1.9.2** Continuous eligibility

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

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

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

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

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

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

- (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
- (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8

- U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) An alien who belongs to one of the following classes:
 - (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
 - (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
 - (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
 - (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
 - (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
 - (vi) Aliens currently in deferred action status; or
 - (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
 - (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
 - (6) An alien who has been granted withholding of removal under the Convention Against Torture;
 - (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));
 - (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
 - (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

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

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

status under section 1137(d) of the Act.

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

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

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

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

in the State plan as well as targeted low-income children.

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

medical condition. This applies to pregnant women as well as targeted low-income children.

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

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

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

children with a lower family income.

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

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

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

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

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

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

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

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

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

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

4.3.3-EL Express Lane Eligibility Check here if the state elects the option to rely on a

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

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

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

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

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

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

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

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

4.4. Eligibility screening and coordination with other health coverage programs

States must describe how they will assure that:

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

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

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

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

~~Health plans and facilitated enrollers are required to screen all CHPlus applicants for Medicaid eligibility. If information and/or documentation submitted by the family at the time of application suggest that the family is eligible for Medicaid, the health plan will forward the application and documentation to the appropriate LDSS office for a Medicaid eligibility determination.~~

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

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

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

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

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

The State monitors prior insurance of applicants to ensure that the program does not substitute for coverage under group health plans. The application on New York State of Health Access ~~NY application used by the State to enroll children~~ asks if the applicant currently has insurance or if they have had coverage within the past ~~six (6)~~ 90 days. If they currently have health coverage, they are not eligible for the program. If they had health coverage, they are questioned if it was through their employer and the reason they no longer have health insurance through their employer. For children under 250 percent of the federal poverty level, the State collects the information on prior health insurance status quarterly from the health plans. This information is analyzed to determine the percentage of new enrollees who have dropped employer-based health insurance for enrollment in CHPlus. If the percentage reaches an average of eight (8) percent for the last three (3) quarters, a six-month waiting period will be imposed. The responsible adult filling out an application must attest to the source and nature of any health care coverage the child is receiving or has received in the past six months.

Children whose gross family income is between 251% and

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

- (a) Loss of employment due to factors other than voluntary separation;
- (b) Death of the family member which results in termination of coverage under a group health plan under which the child is covered;
- (c) Change to a new employer that does not provide an option for comprehensive health benefits coverage;
- (d) Change of residence so that no employer-based comprehensive health benefits coverage is available;
- (e) Discontinuation of comprehensive health benefits coverage to all employees of the applicant's employer;
- (f) Expiration of the coverage periods established by COBRA or the provisions of subsection (m) of section three thousand two hundred twenty-one, subsection (k) of section four thousand three hundred four and subsection (e) of section four thousand three hundred five of the insurance law;
- (g) Termination of comprehensive health benefits coverage due to long term disability;
- (h) The cost of employment based health insurance is more than 5 percent of the family's income;
- (i) A child applying for coverage under these provisions is pregnant;
- (j) A child applying for coverage under this provision is at or below the age of five;
- (k) Child has special health care needs;
- (l) Child lost coverage as a result of a divorce; or
- (m) The cost of family coverage including the child exceeds 9.5% of household income.

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

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

4.4.5. Child health assistance is provided to targeted low-income children in the

State who are American Indian and Alaska Native. (Section 2102(b)(3)(D))
(42 CFR 457.125(a))

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

To further enhance outreach and potential enrollment of Native Americans, several ~~facilitated enrollment~~ IPA/Navigator grantees provide application assistance to tribes throughout the State. This includes a grant with the American Indian Community House.

~~These arrangements are as follows:~~

- ~~• The Southern Tier Health Care System has developed a referral system with the Seneca Nation where facilitated enrollers either meet with potential applicants on the reservation or transportation is provided for the applicant to meet with the facilitated enroller at another location.~~
- ~~• Healthy Community Alliance provides application assistance to the Seneca Nation on the Cattaraugus Reservation.~~
- ~~• The Adirondack Health Institute provides application assistance on the St. Regis Mohawk Reservation one or two days a week.~~
- ~~• The Onondaga Health Department provides application assistance at the Onondaga Nation Clinic monthly and performs home visits to applicants upon request.~~

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

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

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

Section 6. Coverage Requirements for Children’s Health Insurance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

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

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

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

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

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

6.1.4.1. Coverage the same as Medicaid State plan

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

6.1.4.3. Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in 457.420, plus additional coverage. Under this option, the

State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

- 6.1.4.4. Coverage that includes benchmark coverage plus additional coverage
6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

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

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

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

- 6.1.4.7. Other (Describe)

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

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

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

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

- **Inpatient Hospital Medical or Surgical Care**

Scope of Coverage: Inpatient hospital medical or surgical care will be considered a covered benefit for a registered bed patient for treatment of an illness, injury or condition which cannot be treated on an outpatient basis. The hospital must be a short-term, acute care facility and New York State licensed.

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

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

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

Scope of Coverage: Provides services on ambulatory basis by a covered provider for medically necessary diagnosis and treatment of sickness and injury and other conditions including the screening, diagnosis and treatment of autism spectrum disorders. An Autism spectrum disorder means any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders, including autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder or pervasive

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developmental disorder not otherwise specified. All services related to outpatient visits are covered, including physician services.

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

- **Outpatient Surgery**

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

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

- **Emergency Medical Services**

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

Level of Coverage: No limitations.

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

- **Pediatric Health Promotion visits.**

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

Level of Coverage: Includes all services related to visits. Includes immunizations, well child care, health education, tuberculin tests (Mantoux), hearing tests, dental and developmental screening, clinical laboratory and radiological tests, eye screening, and lead screening.

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

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See Section 6.2.2.

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

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

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

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

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

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

The Department will be calculating monthly supplemental payments utilizing the Medicaid prospective payment system (PPS) rates of payment to FQHCs and information provided by the FQHC. Supplemental payments to the FQHC will be made to the FQHC through the participating CHPlus managed care organizations (MCO). Supplemental payments will be made for only claims paid and/or approved by the MCOs and/or their subcontracted Independent Practice Associations (IPAs).

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

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

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

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

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

The Department plans to implement an initiative to incentivize the development of patient-centered medical homes for the CHPlus program. The medical home initiative is based upon the standards developed by the National Committee for Quality Assurance's (NCQA) for the Physician Practice Connections – Patient-Centered Medical Home Program (PPC-PCMH). The PPC-PCMH is a model of care that seeks to strengthen the physician-patient relationship by promoting improved access, coordinated care, and enhanced patient/family engagement. Office-based practitioners (physicians and registered nurse practitioners) and Article 28 clinics that are approved as a medical homes and recognized by the NCQA as meeting the requirements of the PPC-PCMH program, will receive an additional payment for primary care services provided to CHPlus enrollees. Additionally, a subset of providers classified as medical homes came together to establish the Adirondack Medical Home Multipayer Demonstration Program. This Program was established to improve health care outcomes and efficiency through patient continuity and coordination of services. They will receive an additional payment for providing primary care services that differs from the medical home initiative describe above. The additional payment will be included in the per-member per-month all-inclusive premium paid to each MCO. The MCO is responsible for reimbursing the medical home. This initiative is expected to begin on October 1, 2011.

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

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

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

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

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

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

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

- **Diagnostic and Laboratory Tests**

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

Level of Coverage: No limitations.

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

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

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

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

- **Prenatal Care**

See Section 6.2.28.

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

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

Level of coverage: No limitations.

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

- **Outpatient visits for mental health**

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

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

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

- **Durable Medical Equipment (DME)**

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

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

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

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

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

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

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

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

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

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

- **Home Health Care Services**

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

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

- **Diabetic Education and Home Visits**

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

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

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

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

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

Level of Coverage: No limitations.

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

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

Level of Coverage: No limitations.

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

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

Level of coverage: No limitations.

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

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

Level of coverage: No limitations.

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

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

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

- **Speech Therapy**

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

Level of coverage: Those required for a condition amenable to significant clinical improvement within a two-month period, beginning with the first day of therapy.

Covered speech therapy services for a child diagnosed with an autism spectrum disorder shall also be provided if deemed habilitative or non-restorative.

- **Hearing**

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

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

- **Physical and Occupational Therapy**

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

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

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

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

- **Hospice**

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

Level of Coverage: Hospice services include palliative and supportive care provided to a patient to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement. In accordance with Section 2302 of the Affordable Care Act, children are allowed to receive hospice services without forgoing any medically necessary curative services included in

the Child Health Plus benefit package. Hospice organizations must be certified under Article 40 of the NYS Public Health Law. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by federal and state requirements. All services must be provided according to a written plan of care which reflects the changing needs of the patient/family. Family members are eligible for up to five visits for bereavement counseling (bereavement counseling not funded through program).

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

- **Therapeutic Services**

Scope of Coverage: Ambulatory radiation therapy and chemotherapy. Injections and medications provided at time of therapy (i.e., chemotherapy) will also be covered. Hemodialysis will be a covered service. Short term physical and occupational therapies will be covered when ordered by a physician.

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

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

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

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

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

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

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

(ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

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

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

- **Maternity Care**

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

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

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

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

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)

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

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

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

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

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

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

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

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

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Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

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

- 6.3.1.** The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR
- 6.3.2.** The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

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

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

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

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

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

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

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

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

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

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

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

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

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

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

Yes

No

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

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

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

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

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

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

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

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

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

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

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

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

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

- Yes
- No

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

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

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

6.4.3.6-PA Notice of Availability of Premium Assistance- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment

process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

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

APPENDIX I

NEW YORK STATE CHILD HEALTH PLUS BENEFITS PACKAGE

Effective

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Date:
Date:

Approval

CHILD HEALTH PLUS BENEFITS PACKAGE

**No Pre-Existing Condition Limitations Permitted
No Co-payments or Deductibles
April 2013**

Type of Coverage	Scope of Coverage	Level of Coverage
Preventive Health and Wellness 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 Surgical	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: 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 therapy services and supplies; drugs and medications that are not experimental; sera, biological 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; the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electro-encephalographic studies and examination facilities, services, supplies and equipment related to radiation and nuclear therapy; and services, supplies and equipment related to emergency medical care; chemotherapy; and additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the hospital.
Inpatient Mental and Alcohol 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.
Rehabilitation	Acute care services provided by an Article 28 General Hospital	Services, supplies and equipment related to physical medicine and occupational therapy for short-term rehabilitation.
Professional Services for Diagnosis and Treatment of Illness and Injury	Provides services on ambulatory basis by a covered provider for medically necessary diagnosis and treatment of sickness and injury and other conditions. Includes all services related to visits. Professional services are provided on outpatient basis and inpatient basis.	No limitations. Includes wound dressing and casts to immobilize fractures for the immediate treatment of the medical condition. Injections and medications provided at the time of the office visit or therapy will be covered. Includes audiometric testing where deemed medically necessary.

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Level of Coverage	Scope of Coverage	Level of Coverage						
Hospice Services and Supplies	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 stresses 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. Hospice 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 meets the changing needs of the patient/family. Family members are eligible for up to five visits for bereavement counseling.						
Ambulatory 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, ventilators, therapeutic ventilators, nebulizers and other equipment for respiratory care, traction equipment, walkers, wheelchairs and accessories, commode chairs, toilet rails, monitors, patient lifts, nutrition infusion pumps, ambulatory infusion pumps and other miscellaneous DME.</p> <p>DME coverage includes equipment servicing (labor and parts). Examples include, but are not limited to:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Fitted/Customized leg brace</td> <td style="width: 50%;">Not fitted/Customized cane</td> </tr> <tr> <td>Prosthetic arm</td> <td>Wheelchair</td> </tr> <tr> <td>Footplate</td> <td>Crutches</td> </tr> </table>	Fitted/Customized leg brace	Not fitted/Customized cane	Prosthetic arm	Wheelchair	Footplate	Crutches
Fitted/Customized leg brace	Not fitted/Customized cane							
Prosthetic arm	Wheelchair							
Footplate	Crutches							
	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 teeth and provided within twelve months of the accident, and except for dental prostheses 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 surgery are not covered.						
Therapeutic Services	Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (<i>i.e.</i> chemotherapy) will also be covered.	No limitations. These therapies must be medically necessary and under the supervision and referral of a licensed physician. Short term physical and occupational therapies will be covered when ordered by a physician. <u>Physical and occupational therapies for a child diagnosed with an autism spectrum disorder are also covered when such treatment is diagnostic, rehabilitative or nonrestorative.</u> 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.						

Scope of Coverage	Level of Coverage
Visual and Hearing Aids	<p>Hearing examinations to determine the need for corrective action and speech therapy performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist.</p>
Surgical Testing	<p>All tests (laboratory, x-ray, etc.) necessary prior to inpatient or outpatient surgery.</p>
Second Surgical Opinion	<p>Provided by a qualified physician.</p>
Second Medical Opinion	<p>Provided by an appropriate specialist, including one affiliated with a specialty care center.</p>
Home Care for Alcoholism and Substance Abuse	<p>Services must be provided by certified and/or licensed professionals.</p>
Home Health Care	<p>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.</p>
Prescription and Non-prescription Drugs	<p>Prescription and non-prescription medications must be authorized by a professional licensed to write prescriptions.</p>

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 also be provided if deemed habilitative or nonrestorative.

Benefits are available if a physician orders the tests: proper diagnosis and treatment required for 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.

No limitations.

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.

No limitations. Visits may include family therapy for alcohol, drug and/or mental health treatment as such therapy is directly related to the enrolled child's alcohol, drug and/or mental health treatment.

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 a 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 per any calendar year, if such visits are medically necessary.

Prescriptions must be medically necessary. May be limited to generic medications when medically acceptable. Includes family planning or contraceptive medications or devices. Medications used for preventive and therapeutic purposes will be covered. Vitamins are 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.

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al Coverage	Scope of Coverage	Level of Coverage
Emergency Medical Services	<p>For services to treat an emergency condition in hospital facilities. For the purpose of this provision, “emergency condition” means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:</p> <ul style="list-style-type: none"> ⊞ Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; ⊞ Serious impairment to such person's bodily functions; ⊞ Serious dysfunction of any bodily organ or part of such person; or ⊞ Serious disfigurement of such person. 	No limitations.
Ambulance Services	<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>Coverage for non-airborne emergency transportation is based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:</p> <ul style="list-style-type: none"> ⊞ Placing the health of the person afflicted with such condition in serious jeopardy; ⊞ Serious impairment to such person's bodily functions; ⊞ Serious dysfunction of any bodily organ or part of such person; or ⊞ Serious disfigurement of such person.
Maternity Care	<p>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.</p>	No limitations; (however subsidized children requiring maternity care services will be referred to Medicaid).

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al Coverage	Scope of Coverage	Level of Coverage
ic Supplies and ment	Coverage includes insulin, blood glucose monitors, blood glucose monitors for visually impaired, data management systems, test strips for monitors and visual reading, urine test strips, insulin, injection aids, cartridges for visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, oral agents.	As prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law.
ic Education me 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 a patient's symptoms or conditions which necessitate changes in a patient's self-management 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 diabetes educator, certified diabetes 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.
ency, tive and e 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.	<p>The vision examination may include, but is not limited to:</p> <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.
	Contact Lenses	If medically warranted, more than one pair of glasses will be covered. Covered when medically necessary.

Plan Coverage	Scope of Coverage	Level of Coverage
Screening, Diagnosis and Treatment of Autism Spectrum Disorder	Coverage for the Screening, Diagnosis and Treatment of Autism Spectrum Disorders	Includes the following care and assistive communicative devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: <ul style="list-style-type: none"> ☐ Behavioral health treatment; ☐ Psychiatric care; ☐ Psychological care; ☐ Medical care provided by a licensed health care provider; ☐ Therapeutic care, including therapeutic care which is deemed habilitative or restorative; and ☐ Pharmacy care. Applied behavioral analysis shall be covered, subject to a maximum benefit of \$45,000 per calendar year. Assistive communication devices shall be covered when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means such as speech or in writing. Assistive communication devices such as communication boards and speech-generating devices may be rented or purchased, subject to prior approval. Coverage must include dedicated communication devices, which are devices that generally are not useful to a person in the absence of a communication impairment. Items such as laptops, desktops, or tablet computers are not covered items but software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device is a covered item.
Emergency, Preventive and Routine Dental Care	Emergency Dental Care Preventive Dental Care Routine Dental Care Endodontics	Includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma. Includes procedures which help prevent oral disease from occurring, including but not limited to: <ul style="list-style-type: none"> ☐ Prophylaxis: scaling and polishing the teeth at 6 month intervals ☐ Topical fluoride application at 6 month intervals where local water supply is not fluoridated ☐ Sealants on unrestored permanent molar teeth. ☐ Space Maintenance: unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth. Includes: <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 month intervals, or panoramic x-rays at 36 month intervals if necessary; and orthodontic x-rays as required (once primary teeth erupt) ☐ All necessary procedures for simple extractions and other routine dental surgery 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 Includes all necessary procedures for treatment of diseased pulp chamber and pulp canal where hospitalization is not required.

al 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 cuspids) in a patient with an otherwise full complement of natural, functional and/or restorable teeth; 2) Required for cleft-palate treatment or stabilization; 3) Required, as demonstrated by medical documentation, due to the presence of a neurologic or physiologic condition that would preclude the placement of a removable prosthesis.
		NOTE: Refer to the Medicaid Management Information System (MMIS) Dental Provider Manual for a more detailed description of services.
	Orthodontics	<p>Prior approval for orthodontia coverage is required. Includes procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/ mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.</p> <p>Orthodontia coverage is not covered if the child does not meet the criteria described above.</p> <p>Procedures include but are not limited to:</p> <ul style="list-style-type: none"> ☐ Rapid Palatal Expansion (RPE) ☐ Placement of component parts (e.g. brackets, bands) ☐ Interceptive orthodontic treatment ☐ Comprehensive orthodontic treatment (during which orthodontic appliances have been placed for active treatment and periodically adjusted) ☐ Removable appliance therapy ☐ Orthodontic retention (removal of appliances, construction and placement of retainers)

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Child Health Plus
Benefit Package Exclusions
April 2013

The following services will NOT be covered:

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

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