

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

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

State/Territory: New York State

Organization: New York State Department of Health

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**Supervising
Official:** Dennis P. Whalen
Executive Deputy Commissioner

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

(Signature of Governor of State/Territory, Date Signed)

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

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

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

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

- 1.1. Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); OR
- 1.2. Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
- 1.3. **X** A combination of both of the above.

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

2.1. Describe the extent to which, and manner in which, children in the State including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).

Uninsured: The New York State Child Health Plus (CHPlus) program is the largest State-subsidized health insurance program in the nation. Enrollment in the program as of August, 1997 was over 140,000 children statewide. In spite of this effort, the 1996 Current Population Survey (CPS) estimates that there are still approximately 422,000 uninsured children in New York State with gross family incomes below 200% of the Federal poverty level.

Medicaid: Current New York State DOH Office of Medicaid Management estimates indicate that there are approximately 1.3 million children enrolled in Medicaid. It is not possible to divide this estimate into other relevant factors such as race, ethnicity or geographic location at this time due to the manner in which the claim data is reported to the State.

Regional Pilot Project (RPP): As of January 1, 1999, there were approximately 2,600 individuals enrolled in the Regional Pilot Project (RPP).

New York State Small Business Health Insurance Partnership Program (NYSHIPP): As of January 1, 1999, one thousand and twenty eight employers from RPP have been enrolled into NYSHIPP. Since RPP and NYSHIPP are employer-based programs, it is not possible to accurately predict how many uninsured children will have access to health insurance through these programs.

Private Insurance: In 1996, approximately 3.1 million New York State children were covered under private health insurance.

Please refer to Section 2.2.2. for an in-depth discussion on the CHPlus, RPP and NYSHIPP programs.

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

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

New York is committed to improving the health of children. Low income children are at particular risk for illness and injury that affect their health status. These children are more likely to receive care in an emergency room setting for primary health care problems, lack a primary care provider, and become hospitalized for conditions (e.g., asthma) which are potentially preventable with high quality ambulatory care. The health care system in New York is designed to be proactive, providing children with health care that focuses on prevention. The CHPlus program and the Medicaid Managed Care program provide these children with a “medical home,” i.e., the programs provide coverage for primary and preventive health care so children will have access to primary care providers and receive the care they need.

It is the goal of the New York State Department of Health (DOH) that every child receive primary and preventive health care services. Therefore, managed care products need to be available to all eligible children. The department is making every effort to ensure a seamless delivery system that enhances coordination between Medicaid and CHPlus so that children can transition between programs while maintaining their relationships with their primary care providers.

New York State is improving access to health care by: reforming the State's Medicaid Program to a managed care system; reimbursing hospitals for uncompensated care; and subsidizing health insurance for children of low income families.

Section 4.4.5. details the extensive effort the State is putting forth in order to ensure uncovered children are directed to the appropriate insurance program.

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

Child Health Plus Program

The CHPlus program commenced in 1990. The program is based on a partnership between government and private insurers through the subsidization of private health insurance coverage. This program does not provide for Medicaid coverage and is not an entitlement program.

In 1990, Chapters 922 and 923 of the Laws of 1990 (New York Public Health Law sections 2510 and 2511) authorized the Commissioner of Health, in consultation with the Superintendent of Insurance, to establish a statewide program to provide subsidized outpatient health insurance for children under age 13 in low income families. Funding for the program was limited to \$20 million per year. Eligible children began receiving coverage through the CHPlus program in August, 1991. Funding for the program has steadily increased as a result of its success and continuing demands for coverage.

Chapter 731 of the Laws of 1993 continued the CHPlus program through December 31, 1995 and increased funding for the program to \$120 million for a two year period. Under this legislation, the existing contracts with insurers, and outreach and marketing contractors for CHPlus, were extended through 1995. Subsequent legislation was enacted in 1994 and 1995 that expanded CHPlus to eligible children under age 16, continued existing contracts with insurers and required a Request for Proposals (RFP) for marketing and outreach activities.

The New York Health Care Reform Act (HCRA) of 1996 continued the CHPlus program through December 31, 1999 and expanded the program as follows: from July 1, 1996 through December 31, 1996 provides benefits for eligible children under the age of 17; effective January 1, 1997, children under the age of 19 are eligible to participate in the program and inpatient care is a covered benefit; and program funding was significantly increased to allow for the expanded eligibility criteria and benefit package. HCRA increased the funding for the program as follows:

- ! January 1, 1997 through December 31, 1997 - \$109 Million
- ! January 1, 1998 through December 31, 1998 - \$150 Million
- ! January 1, 1999 through December 31, 1999 - \$207 Million

The CHPlus program, as amended by the Health Care Reform Act of 1996, shall continue to assure access to and delivery of high quality, appropriate preventive, primary and inpatient hospital health care services.

New York State Small Business Health Insurance Partnership Program (NYSHIPP)

Program Overview: NYSHIPP is a program established by HCRA which assists employers in providing health care coverage for their employees and dependents by subsidizing 45% of the cost of such coverage. Businesses with between 1 and 50 employees who have not provided group health insurance benefits in the previous 12 months are eligible to participate in the program.

Insurance Policy: Employers must purchase a group health insurance policy or comprehensive health services plan that is offered on a community rated, open enrollment basis. Non-comprehensive policies or riders to existing contracts will not be covered by the program.

Enrollment Process: In order to participate in the program, employers will apply directly to the Department of Health. Existing Regional Pilot Project participating employers will be given first priority for funding. Preference is then given to employers with the lowest average salaries.

State Subsidy: Partnership certificates are awarded to eligible employers stating the amount of the incentive payment which may not exceed 45% of the cost of the premium. Employees may pay up to 10% of the premium cost at the option of the employer.

Regional Pilot (Individual) Project

The Regional Pilot Project assists low-income individuals with the purchase of health care insurance. Under the individual program, uninsured individuals have a portion of their premium costs subsidized by the State on a sliding scale basis, based on family income and family size. The individual is responsible for the remainder of the premium and any other costs associated with the coverage. The State makes a monthly subsidy payment to an insurer to reduce the premium cost to individuals and/or their dependents who are at 200 percent or less of Federal poverty guidelines and have not been insured during the six months prior to application, unless coverage is lost as a result of loss of employment.

These programs allow for insurance opportunities to uninsured individuals and families. Although it is not possible to maintain any type of accurate data on how many children are provided coverage through these public/private programs (other than the CHPlus program), these programs do enroll eligible uninsured children.

Other DOH projects currently underway which focus on a goal of improving children's health include, but are not limited to, the following:

Electronic Birth Certificate/Immunization Registries: DOH is implementing a system of electronic reporting of birth certificate information. This system will simplify and expedite bi-directional transfer of information between DOH and health care providers. The development of a prototype child immunization registry is also underway. This registry will build upon the electronic birth certificate database to allow providers to have access to the immunization status of their pediatric patients.

Lead Screening: The DOH Lead Poisoning Prevention Program has been successful in integrating blood lead screening as part of primary health care for children. More children are being appropriately screened within physicians' offices.

In order to improve the health outcomes of New York State's children, there must also be a corresponding increase in access to health care for children of the working poor who are neither eligible for Medicaid nor covered by health insurance through their employers. The CHPlus program, along with other State initiatives described in this section, are

examples of the State's commitment to providing access to health services for all eligible children.

2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered: (Section 2102(a)(3))

In order to increase coverage for uninsured children in New York State, New York shall expand enrollment in its current CHPlus and Medicaid programs.

Under the CHPlus program, through the purchase of a managed care insurance product, children shall have a primary care provider who shall coordinate his/her health care, including referrals to specialists when appropriate. Whenever possible, CHPlus providers will also be Medicaid managed care providers. Children who enroll in Medicaid or CHPlus may experience changes which make them ineligible for a program, thus, the linkage between the CHPlus program and the New York State Medicaid Managed Care Program will allow children the ability to move between insurance programs without changing providers. Insurers will be chosen to participate in the program as a result of a competitive RFP process. Those plans which are approved New York State Medicaid Managed Care insurers shall be allowed to participate in the CHPlus program without a competitive bid or request for proposal process. The insurers shall contract with the State to provide a managed care product. Insurers will be selected in every geographic region of the State to assure statewide coverage.

As described in depth in Section 7 - Quality and Appropriateness of Care, primary and preventive care services which shall be provided under the program shall be of high quality. To increase enrollment in the program, thereby increasing access to health services, outreach and marketing of the program shall be increased and conducted through a variety of methods.

Section 3. General Contents of State Child Health Plan (Section 2102(a)(4))

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102(a)(4))

Under the CHPlus program, through the purchase of a managed care insurance product, children shall have a primary care provider who shall coordinate his/her health care, including referrals to specialists, when appropriate. Insurers shall be chosen for participation in the program as a result of a competitive Request for Proposal (RFP) process. Those plans which are approved New York State Medicaid Managed Care insurers shall be allowed to participate in the CHPlus program without a competitive bid or request for proposal process. The insurers shall contract with the State to provide a managed care product. Insurers shall be selected in every geographic region of the State to assure statewide coverage.

New York's Title XXI State Plan includes both Medicaid coverage for children and an insurance program (known as Child Health Plus). As described in the state's amendment to its Title XIX (Medicaid) State Plan the state will expand Medicaid to include children ages 15-18 in families with incomes at or below 100% of the federal poverty level effective January 1, 1999. The Child Health Plus insurance program will serve all children below age 19 in families with household incomes at or below 192% of the federal poverty level effective January 1, 1999.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102(a)(4))

Utilization control mechanisms are in place for the CHPlus program to ensure that children use only health care that is appropriate, medically necessary, and/or approved by the State or the participating health plan.

Before being approved for participation in the CHPlus program, health plans must develop and have in place utilization review policies and procedures that include protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims meeting pre-defined criteria. Plans also must develop procedures for identifying and correcting patterns of over and under utilization on the part of their enrollees.

More information can be found on utilization control in Section 7 - Quality and Appropriateness of Care.

Section 4. Eligibility Standards and Methodology (Section 2102(b))

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

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102(b)(1)(A)) Standards used to determine eligibility for the Medicaid program are identified in the Title XIX (Medicaid) State Plan.

4.1.1. Geographic area served by the Plan

4.1.2. X Age:

A child is eligible for the CHPlus and Medicaid programs if the child is less than 19 years of age.

Proof of Age for CHPlus. Documentation of proof of age shall include one of the following: copy of birth certificate; religious documents (baptismal papers); school records; and/or signed affidavit stating witness of birth.

4.1.3. X Income:

A child is eligible for the Medicaid program if the child resides in a household having an income at or below 100% of the non-farm federal poverty level. A child is eligible for the CHPlus program if the child resides in a household having a net household income at or below 192% of the non-farm Federal poverty level (as defined and annually revised by the federal Office of Management and Budget) or the gross equivalent of such net income.

Income Documentation for CHPlus. The means test for income shall include any one of the following: annual Federal and State tax returns, paycheck stubs or other documentation of income; written documentation by employer; a WIC "Income Residency Documentation Form" or an affidavit of self-income declaration. If the income level has changed since last year's income, documentation supporting the current income is required. Income for the purposes of this plan means gross income before deduction of income taxes, employees' social security taxes, insurance premiums, bonds, etc. Income includes the following:

1. Monetary compensation for services, including wages, salary, commissions or fees;
2. Net income from farm and non-farm employment;
3. Social Security;

4. Dividends or interest on savings bonds, income from estates or trusts, or net rental income;
5. Public Assistance;
6. Unemployment compensation;
7. Government civilian employee or military retirement or pensions or veterans' payments;
8. Private pensions or annuities;
9. Alimony or child support payments;
10. Regular contributions from persons not living in the household;
11. Net royalties; and
12. Other cash income. Other cash income includes but is not limited to: cash amounts received or withdrawn from any source including savings, investments, trust accounts, and other resources which are readily available to the family.

4.1.4. Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. X Residency:

A child must be a resident of New York State.

Proof of residency for CHPlus : School records, utility bills or any mail addressed to the child and/or responsible adult which has been postmarked may be used as proof of residency.

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

4.1.7. X Access to or coverage under other health coverage:

Efforts to Minimize Crowd-Out: "Crowd-out" is when a State program is accessed to provide coverage for children when private insurance coverage is otherwise available. For example, a family may decide to drop group coverage for the individual coverage of CHPlus since the premium is less than what they would pay for group insurance coverage. Every effort will be made by New York State to minimize the effects of crowd-out in the CHPlus program.

New York State has a great deal of experience with child health insurance programs. An evaluation of the CHPlus program has shown that "crowd-out" has not been an issue. In the past, individuals have not been shown to drop employer based coverage for the CHPlus program. In addition, New York State has other insurance programs for the uninsured: the Regional Pilot Program and the New York State Small Business Health Insurance Partnership Program. Individuals, small

businesses and sole proprietors may apply for financial assistance to purchase health insurance. The State shall continue to minimize the effect of "crowd-out" with the implementation of the Federal CHPlus program through the continuation of these efforts to assist the uninsured and assist employers in providing coverage. As described in section 4.4.3 the State is collecting data on prior health insurance status in order to monitor potential crowd-out.

In the CHPlus program, there shall be a premium contribution for children whose income is above 160% of the Federal Poverty Level, which is the group most likely to have access to employer coverage. This family contribution is a disincentive for families to drop group employer coverage for the CHPlus program.

Since the CHPlus benefit package was designed to be similar to the standard benefit levels offered through most employers, there is no incentive to drop employer-based dependent coverage in favor of CHPlus based on benefit levels alone.

4.1.8. X Duration of eligibility

CHPlus Presumptive Eligibility. A 60 day presumptive period of eligibility is available to applicant children as a means of providing services under CHPlus when a child appears eligible for the program, but, pertinent documentation is lacking. The insurer performs an initial review of the child's age, family's gross income, residency, and health care coverage, and from the completed application determines whether the child appears eligible. If one or more pieces of the documentation to support these variables is not submitted with the application, the family is allowed up to 60 days to submit the additional material or the child is disenrolled from the program. Only one period of presumptive eligibility per child is allowed.

Effective January 1, 1999 any child under the age of 19 whose family's household income does not exceed 192% of the non-farm federal poverty level shall be presumed eligible for Child Health Plus coverage. This period of presumptive eligibility shall continue until the earlier of the date a Medicaid or Child Health Plus eligibility determination is made or sixty (60) days after the presumptive eligibility period begins. If a child is determined not to be eligible for Medicaid prior to the last day of the sixty day presumptive eligibility period, such child may continue to be presumed eligible for Child Health Plus until the earlier of the date a Child Health Plus eligibility determination is made or the last day of the sixty day presumptive eligibility period. A presumptive eligibility period may be extended in the event a Medicaid eligibility determination is not made within the sixty day period through no fault of the applicant, as long as all the required documentation has been submitted within the sixty day period.

Period of eligibility. The period of eligibility shall commence on the first day of the month during which a child is an eligible child or on the first day of the month of

application, whichever is later, and end on the last day of the month in which a child ceases to be an eligible child or up to the last day of the third month after an eligible child becomes eligible for medical assistance, whichever is earlier. Annual recertification is done whereby all documentation must be confirmed by the insurer.

4.1.9. Other standards (identify and describe):

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

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

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

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

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

For CHPlus, the State shall be responsible for establishing the means test (income) used to define eligibility. There shall be no resource test (asset) required for program eligibility. The insurer shall be responsible for obtaining and maintaining all documentation necessary to determine eligibility for the Child Health Plus program. Eligibility for the Medicaid program will be determined by the local district social services (LDSS) offices.

Enrollment procedures for CHPlus. Enrollment into the CHPlus program can be initiated in three ways: through the insurer, through the Healthy Baby Hotline and/or through a community outreach and marketing contractor. CHPlus applications are available through participating insurers.

The Healthy Baby Hotline, a New York State sponsored referral service, is a toll-free number which refers callers to health and social programs. CHPlus is one of the options available to callers and many are referred to participating insurers and/or Medicaid.

The community outreach and marketing contractor is responsible for a telephone hotline to refer families to CHPlus and/or Medicaid; printing and distributing of brochures and posters; and conducting training sessions for interested organizations. Additional activities include health fairs, immunization drives, and establishment of

linkages with schools and other community-based organizations.

The DOH developed a brochure which lists participating insurers by geographical service area and toll-free hotlines that applicants can call for more information on enrollment.

Insurer Responsibility for CHPlus. Insurers shall be responsible for enrolling children into the CHPlus program. To do this, the insurer must:

- ! market the CHPlus program to eligible populations of children;
- ! accept an application from the eligible child and request the required documentation;
- ! collect and evaluate documentation of age, income, insurance status, and New York State residency;
- ! refer children who appear Medicaid eligible to the Medicaid program and forward the names of such individuals to DOH;
- ! submit names and addresses of household members of applicants to DOH for comparison with tax records in cases where the insurer has reasonable cause to believe fraudulent income documentation has been submitted;
- ! if the applicant is presumptively enrolled, request the applicant to submit missing enrollment documentation within 60 days. If the family fails to provide documentation, the child's coverage will be terminated at the end of the 60 days (except if a Medicaid application is pending).
- ! if the applicant is presumptively enrolled and has been referred to the Medicaid program to submit an application and the determination has not been made within sixty days, follow-up on the status of the applicant's Medicaid application with the appropriate local district social services (LDSS) office on a monthly basis, commencing on or about the 120th day following the completion of the Child Health Plus application. These procedures will be followed once the facilitated enrollment is in place as specified in Section 5.1.

The DOH has the authority to audit each insurer on an annual basis to make sure the above processes are in place and followed.

Re-certification/Termination of Coverage for CHPlus. The CHPlus subsidy and coverage shall be terminated or not renewed upon annual re-certification for the following reasons: the child reaches the age of 19; the family's gross income exceeds the eligibility criteria; the child becomes eligible for Medicaid; the child no longer

resides in the service area of the insurer; and/or the child has other health insurance coverage. Children who "age out" of CHPlus are disenrolled from the plan on the last day of the month in which they reach 19 years.

Eligibility re-certification based on income, coverage under Medicaid or other health insurance, and New York State residency must be performed on an annual basis by the anniversary date of the child's enrollment. Children who are found to be enrolled in Medicaid shall be disenrolled from CHPlus. Children who do not submit required re-certification and appropriate documentation by the last day of the month prior to the child's anniversary date, must be disenrolled by the insurer from the program.

Enrollees are required to notify insurers if their circumstances change and when they are no longer eligible for CHPlus. These changes can include income changes where they are no longer eligible for subsidy, or coverage changes, including Medicaid eligibility.

It is the insurer's responsibility to offer a conversion policy to children who become ineligible for participation in CHPlus if the child no longer resides in the service area of the insurer. If an insurer is unable to offer a conversion policy from their own organization then they must provide information on insurance options available to such children in other service areas.

The DOH will review, on an annual basis, eligibility verification and re-certification procedures by each insurer to ensure children are enrolled appropriately. This shall include an annual review of a statistically valid sample of cases from each insurer

through site visits and/or desk audits to determine adherence to enrollment policies and procedures.

4.4. Describe the procedures that assure:

4.4.1. Through intake and follow-up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the State child health plan. (Section 2102(b)(3)(A))

New York State assures that through intake and follow-up screening, that only targeted low-income children are enrolled in the CHPlus program. The procedures for determining eligibility or non-eligibility are described in section 4.4.2.

4.4.2. That children found through the screening to be eligible for medical assistance under the State Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102(b)(3)(B))

Insurers are required to screen all CHPlus applicants for Medicaid eligibility. If

information and/or documentation submitted by the family at the time of application suggests that the family may be eligible for medical assistance, the insurer must refer the family to the Medicaid program. At the time of application the insurer is required to complete a Medicaid referral form. This form contains adequate income information which is used to screen applicants for both CHPlus and Medicaid eligibility. In addition to the required referral form data, the insurer also collects additional information such as the amount of any insurance premiums paid on behalf of the child, if the child is covered by any other health insurance, and any child care costs. These amounts are then deducted and a net monthly income, for purposes of determining Medicaid eligibility, is calculated. If the child appears Medicaid eligible based on the screen, the parent or legally responsible adult is provided with a brochure (by the State) describing the Medicaid program and application process and is directed to apply to the Medicaid program through their local district office. Additionally, each insurer will compile a list of all applicants who appear Medicaid eligible. This list will be distributed electronically to the appropriate local Department of Social Services (DSS) office on a monthly basis. The local DSS office will then contact the potential enrollee and provide a Medicaid application along with enrollment information. This additional process will be coordinated Statewide to enhance the enrollment of Medicaid eligible children into the Medicaid program. Children who are found ineligible for Medicaid through this process may enroll in Child Health Plus. Documentation of these referrals is required and reviewed at the time of the site visit. It is anticipated that very few cases referred to Medicaid, as a result of a screening, shall not be Medicaid eligible since the screening instrument used is comprehensive, reliable and accurate. The insurers are provided information regarding Medicaid outstations where families can apply for Medicaid. These "outstations" are found in many hospitals and clinics and have facilitated the ease of the application process.

The insurers are responsible for referring the family/child directly to the local DSS or outstation, which assists these families with applications to the Medicaid program. Likewise, local DSS staff refer families with eligible children, who have been denied Medicaid or disenrolled from Medicaid, to the CHPlus program.

A joint application process for Medicaid, CHPlus, and the Special Supplemental Food Program for Women, Infants, and Children (WIC) is currently being developed. The joint application will simplify administrative processes for both patients and providers and assure that the child is directed to the correct program.

Eligibility and enrollment are coordinated by CHPlus insurers and local social service agencies so that children applying for CHPlus who qualify for Medicaid are referred to the Medicaid program, and children who do not qualify for Medicaid are referred to the CHPlus program. In addition, there are mechanisms in place to limit the period of dual enrollment in CHPlus and Medicaid. Computerized information on enrollees in CHPlus and Medicaid are compared monthly to identify dually enrolled children.

Currently, CHPlus enrollees are compared to the State's Medicaid enrollment files on a monthly basis to determine dually enrolled children. Those children who are enrolled in

both programs are disenrolled from CHPlus, unless they supply proof they are not enrolled in Medicaid. This process shall continue.

The following chart identifies the income level for Medicaid Coverage:

Individual / Age	Net Family Income (Federal Poverty Level %)
Pregnant women	<185% FPL
Children <1	<185% FPL, without an asset test
Children <6	<133% FPL, without an asset test
Children 6 - <u>18</u>	<100% FPL, without an asset test

4.4.3. That the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C))

It is the insurer’s responsibility to ensure that when enrolling children into the CHPlus program, the program will not substitute for coverage under group health plans. The State will collect information quarterly on prior health insurance status in order to prevent potential crowdout. An insurer will collect and evaluate age, income, insurance status, and New York State residency documentation submitted by the applicant. The responsible adult filling out the enrollment documentation must attest to the source and nature of any health care coverage the child is receiving. The CHPlus application contains a section inquiring about any additional health insurance. The application contains a question (e.g., “Does the child have any other health insurance or Medicaid?”) which must be answered yes or no. If the answer is yes, the insurer must request documentation of such other insurance. If the child has insurance coverage, he/she is not eligible for CHPlus.

4.4.4. The provision of child health assistance 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). (Section 2102(b)(3)(D))

As stated in section 4.4.1. the CHPlus program shall provide statewide coverage. Through this statewide coverage, the provision of health assistance will be ensured 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). The Department

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.

4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102(b)(3)(E))

Please refer to Section 4.4.2.

Section 5. Outreach and Coordination (Section 2102(c))

Describe the procedures used by the State to accomplish:

5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))

Effective marketing, outreach and ease of enrollment are necessary to ensure the success of the CHPlus and Medicaid programs. Under the programs, community outreach and marketing shall occur through: (1) a community outreach contractor which shall be selected through a competitive RFP process; (2) participating insurers; (3) local social services and DOH agencies; (4) a statewide media campaign conducted by DOH; and (5) contracts with community based organizations, providers, school-based health centers and/or local governments selected through a competitive RFP process.

Marketing of each program also includes telephone hot-lines used to refer children to Medicaid or CHPlus and provide linkages with schools and community-based organizations.

Requirements for outreach and marketing of the programs include: telephone hot-lines to refer families to CHPlus and/or Medicaid, distributing brochures and posters, and conducting training sessions for interested organizations. Additional activities include health fairs, immunization drives, and the establishment of linkages with schools and community-based organizations. Insurers may use radio, television, billboards, newspapers, leaflets, brochures, yellow page advertisements, letters, posters and verbal presentations by marketing representatives as well as health fairs and events to market their product to eligible children. Themes and materials for health fairs must be submitted by the insurer to DOH for approval at least thirty (30) days prior to the event.

CHPlus approved insurers are responsible for marketing the CHPlus program in their service areas. In addition, the DOH conducts marketing.

All approved insurers must develop a comprehensive plan of all marketing and enrollment activities they shall engage in during their contract period with the State. The plan must be submitted to the DOH for review and approval prior to implementation. Any subsequent change or additions to an insurer's marketing plan must be submitted to the DOH at least thirty (30) days prior to implementation and must be approved by DOH prior to implementation of such plan or change.

Insurers may distribute marketing material in local community centers and gathering places, markets, pharmacies, hospitals, schools, health fairs and other areas where potential beneficiaries are likely to gather. Door-to-door distribution of material is not permitted. Insurers may not offer incentives of any kind to CHPlus recipients to join a

health plan. Incentives are defined as any type of inducement, either monetary or in-kind which might reasonably be expected to result in the person receiving it to join a plan. However, insurers may offer nominal gifts of not more than five dollars (\$5.00) in value as part of a health fair or other promotional activity to stimulate interest in the CHPlus program. These nominal gifts must be given to everyone who requests them regardless of whether or not they intend to enroll in the plan.

Efforts are underway to contract with a number of entities such as community based organizations, child advocacy groups, health care providers, school-based health centers and local governments to do outreach and enrollment for CHPlus and Medicaid. These efforts will be directed toward facilitated enrollment in community-based settings. Approximately \$10 million will be available for contracts on a regional basis to support locally-tailored programs to develop and implement the necessary enrollment infrastructure. Organizations which demonstrate their ability to maximize the enrollment of eligible children and ultimately improve access to care and health outcomes will be selected. Facilitated enrollment entails providing families with necessary information about eligibility, assisting them in completing the applications and routing applications to either the health plan for enrollment in CHPlus or the local social services district for enrollment in Medicaid. The facilitated enrollers will be available during evening and weekend hours, making enrollment more convenient for working families. By removing the barriers to enrollment in today's system, DOH can ensure that each child enters the system and receives services through the "right door", without families having to search for that door. In doing so, DOH will create a system that balances and coordinates federal and state statutes with the goal of enrolling targeted low-income children.

5.2. Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))

A joint application process for Medicaid, CHPlus, and the Special Supplemental Food Program for Women, Infants, and Children (WIC) is currently under development. The joint application shall simplify administrative processes for both patient and providers and assure that the child is directed to the correct program. In the fall of 1998 two pilot projects were begun to test the new application. The Children's Defense Fund in New York City has partnered with community-based organizations and students from Columbia University to reach out to uninsured children in Washington Heights and Inwood, two minority communities, to enroll them in Medicaid or Child Health Plus. The enrollment process involves the use of the single application. The second pilot project is the Statewide Youth Advocacy Group partnering with a number of children day care centers in New York City. Day care workers have been trained in the use of the single application and assist families in enrolling in Child Health Plus and Medicaid. Once the pilot testing has been completed, the application will be reviewed with a scheduled statewide implementation for late 1999.

Section 6. Coverage Requirements for Children’s Health Insurance (Section 2103)

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan, and continue on to Section 7.

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

6.1.1. Benchmark coverage; (Section 2103(a)(1))

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

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

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

6.1.2. Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). See instructions.

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

In calendar year 1996, premium payments to participating CHPlus insurers totalled \$71,000,298. Statewide outreach and marketing expenditures were \$507,642. Therefore, the calendar year 1996 State CHPlus expenditures for premium payments to insurers and community outreach and marketing was \$71,507,940.

The description of New York's benefit package is attached as Appendix I. The package is administered through State contracts with participating insurers and was enacted in 1990 through Chapters 922 and 923 of the Laws of 1990 (New York Public Health Law sections 2510 and 2511). The program was further amended through Chapter 731 of the Laws of 1993, Chapter 170 of the Laws of 1994, Chapter 731 of Laws of 1994, Chapter 80 of the Laws of 1995, the Health Care Reform Act of 1996 and Chapter 2 of the Laws of 1998.

6.1.4. Secretary-Approved Coverage. (Section 2103(a)(4))

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))

A description of coverage for the Medicaid program is specified in the Title XIX (Medicaid) State Plan.

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: 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. Includes 365 days per year coverage for inpatient hospital services and services provided by physicians and other professional personnel for covered inpatient services; bed and board, including special diet and nutritional therapy; general, special and critical care nursing service, but not private duty nursing services; facilities, services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care; oxygen and other inhalation therapeutic services and supplies; drugs and medications that are not experimental; sera, biologicals, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies; blood products,

except when participation in a volunteer blood replacement program is available to the insured or covered person, and services and equipment related to their administration; facilities, services, supplies and equipment related to physical medicine and occupational therapy and rehabilitation; facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electro-encephalographic studies and examinations; facilities, services, supplies and equipment related to radiation and nuclear therapy; facilities, services, supplies and equipment related to emergency medical care; chemotherapy; any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the hospital. There shall be no co-payment or deductibles.

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

! Professional Services for Diagnosis and Treatment of Illness and Injury

Scope of Coverage: Provides services on ambulatory basis by a covered provider for medically necessary diagnosis and treatment of sickness and injury and other conditions. All services related to outpatient visits are covered, including physician services.

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

! Outpatient Surgery

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

Level of Coverage: The utilization review process will ensure that the ambulatory surgery is appropriately provided. No co-payments or deductibles.

! 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.

Co-payments/Deductibles: No co-payments or deductibles.

6.2.3. X 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 DOH recommended immunization schedule.

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. No co-payment or deductibles.

! Professional Services for Diagnosis and Treatment of Illness and Injury

See Section 6.2.2.

6.2.4. X 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. No

co-payments or deductibles.

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

See Section 6.2.2.

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

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

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

Co-payments/Deductible: No copayments or deductibles.

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

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

Level of Coverage: All medications used for preventive and therapeutic purposes will be covered.

6.2.8. X 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. No co-payments or deductibles.

6.2.9. X 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. X 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: A combined 30 days per calendar year for services under sections 6.2.10 and 6.2.18.

6.2.11. X 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: Provides a maximum of 60 outpatient visits per year (combined benefit with alcoholism and substance abuse - see 6.2.19.). No co-payment or deductibles.

6.2.12. X 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 (ie 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. No co-payments or deductibles.

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

! Diabetic Supplies and equipment

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

Level of Coverage: As prescribed by a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law. No co-payments or deductibles.

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

! Home Health Care Services

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

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. No co-payment or deductibles.

! 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. No co-payments or deductibles.

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

6.2.16. X 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. No co-payments or deductibles.

6.2.17. X Dental services (Section 2110(a)(17))

6.2.18. X 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: Limited to a combined 30 days per year for services under sections 6.2.10 and 6.2.18.

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

! Outpatient visits for the diagnosis and treatment of alcoholism and substance abuse.

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

Level of Coverage: Provides a maximum of 60 outpatient visits per year (combined benefit with mental health - see 6.2.11.) No co-payment or deductibles.

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

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

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

Scope of coverage: Speech therapies.

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.

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

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

! Therapeutic Services.

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

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

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

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

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

6.2.28. X 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 subsidized children requiring maternity care services will be referred to Medicaid).

Co-payments/Deductibles: No co-payment or deductible.

6.3. Waivers - 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 waiver. Review and approval of the waiver application(s) will be distinct from the State plan approval process. To be approved, the State must address the following: (Section 2105(c)(2) and(3))

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

- 6.3.1.1. 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))
- 6.3.1.2. 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; and Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii))
- 6.3.1.3. 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(d)(5)(F) or 1923 of the Social Security Act. Describe the community based delivery system. (Section 2105(c)(2)(B)(iii))
- 6.3.2. Purchase of Family Coverage. Describe the plan to provide 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))
- 6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the State would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A))
- 6.3.2.2. 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))

Section 7. Quality and Appropriateness of Care

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

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

Health plans participating in the CHPlus program must provide specific quality performance data to the DOH which is consistent with the New York State Department of Health Quality Assurance Reporting Requirements (QARR) data specifications, on an annual basis for the CHPlus population.

The following reporting requirements will be necessary for insurers to participate in the CHPlus program. Requirements include, but are not limited to, the following:

Membership

- ! Member months of enrollment by age, sex and payer
- ! Enrollment by county

Utilization

- ! Frequency of selected conditions
- ! Inpatient care
- ! Ambulatory care
- ! Maternity care
- ! Newborn care
- ! Disenrollment rate

Quality

- ! Prenatal care: low birth weight, entry in first trimester, initial prenatal care visit, number of prenatal care visits, stage of pregnancy at time of enrollment
- ! Well child care visits in first year of life
- ! Age 4, 5, and 6 year old well child visits
- ! Adolescent well child care visits (age 12-18)
- ! HIV education (age 12-18)
- ! Substance abuse counseling (age 12-18)
- ! Immunizations
- ! Mental health follow-up

Access & Member Satisfaction

- ! Utilization of primary care providers by children

- ! Availability (waiting times for scheduled appointments)
- ! Uniform member satisfaction
- ! Provision of urgent and emergency medical care

General Plan Management

- ! Quality and service improvement studies
- ! Case management
- ! Utilization management
- ! Risk management
- ! Provider compensation
- ! New member orientation/education
- ! Language services
- ! Arrangements with public health, education and social services

Quality. Health plans must have internal quality assurance programs and written quality improvement or assurance plans (Quality Improvement Programs/Quality Assurance Programs (QAP)) for monitoring and improving the quality of care furnished to members. Such plans must address all of the following:

- ! description of quality assurance committee structure;
- ! identification of departments/individuals responsible for QAP implementation;
- ! description of manner in which network providers may participate in QAP;
- ! credentialling/recredentialling procedures;
- ! standards of care;
- ! standards of service accessibility;
- ! medical records standards;
- ! utilization review procedures;
- ! quality indicator measures and clinical studies;
- ! quality assurance plan documentation methods; and
- ! description of the manner in which quality assurance/quality improvement activities are integrated with other management functions.

Health plans must institute a credentialling process for their providers that includes, at a minimum, obtaining and verifying the following information:

- ! evidence of valid current license and valid DEA certificate, as applicable;
- ! names of hospitals, health maintenance organizations (HMOs), prepaid health services plans (PHSPs), and medical groups with which the provider has been associated;
- ! reasons for discontinuance of such associations;
- ! level of malpractice coverage;
- ! pending professional misconduct proceedings or malpractice actions and the substance of such allegations;
- ! substance of any findings from such proceedings;
- ! sanctions imposed by Medicare or Medicaid;

- ! names and relevant information of providers who shall serve as on-call designees for the provider (applies to non-staff, group models only).

Plans must ensure that all on-call providers are in compliance with plan credentialling standards, including any non-participating providers serving in this capacity;

- ! attestation of provider as to validity of information provided;
- ! information from other HMOs or hospitals with which provider has been associated regarding professional misconduct or medical malpractice, and associated judgments/settlements, and any reports of professional misconduct by a hospital;
- ! review of provider's physical site of practice;
- ! review of provider's capacity to provide such services, based on practice size and available resources; and
- ! review of National Practitioner Data Bank profile.

Health plans must also recredential their providers at least once every two years. During such recredentialling, plans should re-examine the items covered during the initial credentialling, as well as complaints lodged against the provider by plan members and results of chart audits and other quality reviews.

Health plans must develop and have in place utilization review policies and procedures that include protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims meeting pre-defined criteria. Plans also must develop procedures for identifying and correcting patterns of over- and under-utilization on the part of their enrollees.

Quality Assurance/Utilization Review. The insurer shall be responsible for ensuring that the services and providers under CHPlus meet the quality of care standards required in the Public Health Law and related regulations.

Additional DOH sponsored quality assurance studies may be conducted during the contract period. The insurers shall have a contractual responsibility to work with the DOH or its agent to complete the quality assurance study within the specified time frames. This shall include supplying the medical records of enrolled children who are selected for the study sample and responding to inquiries from the contractor.

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

Please refer to section 7.1 for specifics on the following activities.

- 7.1.1. X Quality standards**
- 7.1.2. X Performance measurement**

7.1.3. X Information strategies

7.1.4. X Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (Section 2102(a)(7)(B))

In order to participate in the CHPlus program, health plans must establish and maintain provider networks with sufficient numbers of providers in geographically accessible locations for the populations they serve. Health plan networks must contain all of the provider types necessary to furnish the prepaid benefit package, including: hospitals, physicians (primary care and specialist), mental health and substance abuse providers, allied health professionals, pharmacies, and DME providers. Health plans shall not include in their networks, for purposes of serving CHPlus enrollees, any medical provider who has been sanctioned by Medicare or Medicaid if the provider has, as a result of the sanctions, been prohibited from serving Medicaid clients or receiving medical assistance payments.

Service Accessibility: The State considers service accessibility to be one of the key determinants of quality of care and overall member satisfaction. Accordingly, health plans will be expected to take all necessary measures to ensure compliance with the access standards. The State will actively monitor health plan performance in this area and will take prompt corrective action if problems are identified.

Twenty-Four (24) Hour Coverage: Health plans must provide coverage to members, either directly or through their Primary Care Providers (PCPs), twenty-four (24) hours a day and seven (7) days a week. Health plans must instruct their members on how to obtain services after business hours and on weekends.

Telephone Access: Health plans may require their PCPs to have primary responsibility for serving as an after hours "on-call" telephone resource to members with medical problems. If the PCP performs this function, he/she cannot be permitted to "sign-out" (i.e., automatically refer calls) to an emergency room.

Whether or not the plan assigns primary responsibility for after hours telephone access to a PCP, it must have a twenty-four hour toll free telephone number for members to call which is answered by a live voice (answering machines are not acceptable).

Days to Appointment: Health plans must abide by the following appointment standards:

- ! urgent medical or behavioral problems within 24 hours;
- ! non-urgent "sick visits" within 48 to 72 hours, as clinically indicated;
- ! routine, non-urgent or preventive care visits within four weeks; and
- ! in-plan, non-urgent mental health or substance abuse visits within two weeks.

Emergency Services: Health plans are prohibited from requiring members to seek prior

authorization for services in a medical or behavioral health emergency. Plans must inform their members that access to emergency services is not restricted and that if the member experiences a medical or behavioral health emergency, he/she may obtain services from a non-plan physician or other qualified provider, without penalty. However, health plans may require members to notify the plan or their PCP within a specified time after receiving emergency care and may require members to obtain prior authorization for any follow-up care delivered pursuant to the emergency.

Section 8. Cost Sharing and Payment (Section 2103(e))

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. YES

8.1.2. NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income:
(Section 2103(e)(1)(A))

8.2.1. Premiums: Families with income levels between 133% and 185% of the Federal poverty level shall contribute \$9 per child per month up to a family maximum of \$27 per month. Families with income levels between 186% and 192% of the Federal poverty level shall contribute \$15 per child per month up to a family maximum of \$45 per month.

8.2.2. Deductibles: There are no deductibles.

8.2.3. Coinsurance: There are no co-payments.

8.2.4. Other: _____

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income:

The cost sharing information is disseminated to potential enrollees through an informational brochure, a toll-free information and enrollment number and through the enrollment process with the insurers.

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

8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))

8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))

8.4.3. No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under

1916(b)(1).

- 8.4.4. **No Federal funds will be used toward State matching requirements.** (Section 2105(c)(4))
- 8.4.5. **No premiums or cost-sharing will be used toward State matching requirements.** (Section 2105(c)(5))
- 8.4.6. **No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under this title.** (Section 2105(c)(6)(A))
- 8.4.7. **Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997.** (Section 2105(d)(1))
- 8.4.8. **No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.** (Section 2105(c)(7)(B))
- 8.4.9. **No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above).** (Section 2105(c)(7)(A))

- 8.5. **Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved:** (Section 2103(e)(3)(B))

The DOH has reviewed the cost sharing requirements for each family size and income level to ensure that in no instance will the cost sharing requirement exceed five percent of a family's annual income for the relevant year. There are no copayments for the CHPlus program therefore aggregate cost sharing will never exceed five percent of a family's annual income.

- 8.6. **The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:**

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

8.6.2. 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 6.3.2. of the template). Pre-

existing medical conditions are permitted to the extent allowed by
HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:

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

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

The strategic objective for the CHPlus Program will be to provide access to inpatient, outpatient, primary and preventive health care services to low income children by removing financial barriers and providing a medical home through a managed care product.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3))

The following performance goals and measures will be utilized to measure the effectiveness of the CHPlus Program to meet this objective:

- ! Performance Goal: Reduce the number of uninsured children in the State;
Performance Measure: Analysis of current population survey (CPS) data to ensure that the number of uninsured children in the State are declining; Medicaid enrollment increase; CHPlus enrollment increase.

- ! Performance Goal: Program is accessible to all families with qualified uninsured children having a knowledge of program availability;
Performance Measure: Outreach is being conducted in all areas of the State and parent and insurer satisfaction are high. County specific enrollment is studied to target outreach activities. Hotline calls are tracked to monitor success of outreach.

- ! Performance Goal: Children have better health care status;
Performance Measure: Health care indicators are increasing and all children are receiving required preventive health care services, see Section 9.3.1.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B))

Insurers are responsible for submitting reports to DOH regarding the progress of their enrollment. These reports include: monthly enrollment reports (detailing new and ongoing enrollment and disenrollment, quarterly disenrollment reports, quarterly reports on applicants prior health insurance status to assess the potential for crowd-out.

semi-annual and annual financial and utilization reports, annual progress reports (detailing marketing and enrollment outcomes), demographic characteristics of enrollees and utilization outcomes.

DOH has an on-site monitoring program which consists of at least one annual visit to each insurer to review a random sample of individual enrollee's application records. The insurers are notified in advance of the visit and told which enrollment files are selected for the sample. A report is generated to notify the insurer of any deficiencies found or corrections needed. Periodic, focused desk reviews of selected enrollment files are also performed.

Data collection, records, and reports. The CHPlus program assures that the State shall collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under this title.

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

- 9.3.1. **The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.**
- 9.3.2. **The reduction in the percentage of uninsured children.**
- 9.3.3. **The increase in the percentage of children with a usual source of care.**
- 9.3.4. **The extent to which outcome measures show progress on one or more of the health problems identified by the State.**
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. **If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:**
 - 9.3.7.1. **Immunizations**
 - 9.3.7.2. **Well child care**
 - 9.3.7.3. **Adolescent well visits**
 - 9.3.7.4. **Satisfaction with care**
 - 9.3.7.5. **Mental health**

- 9.3.7.6. Dental care
- 9.3.7.7. Other, please list: _____

9.3.8. Performance measures for special targeted populations.

9.4. X The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1))

9.5. X The State assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the State’s plan for these annual assessments and reports. (Section 2107(b)(2))

The Commissioner of Health shall report annually to the Governor and New York State Legislature on the implementation of the program of primary and preventive health care services coverage. Such a report shall include, but not be limited to: a status report on implementation of the program including the number of individuals enrolled profiled by age and geographic location and the number and location of contractual arrangements entered into; the impact of such program on access to primary and preventive health care services; the effect, expenditures and activities of the community-based outreach program; the number of children for whom an application for insurance coverage has been made and enrollees who were determined to be ineligible and the reasons therefore.

Annual Report. The State shall provide an annual report to the Secretary which shall assess the operation of the State plan under this title in each fiscal year, including the progress made in reducing the number of uncovered low-income children. The State shall report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

9.6. X The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3))

9.7. X The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e))

- 9.8.1. **X** Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. **X** Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. **X** Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. **X** Section 1115 (relating to waiver authority)
- 9.8.5. **X** Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
- 9.8.6. **X** Section 1124 (relating to disclosure of ownership and related information)
- 9.8.7. **X** Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8. **X** Section 1128A (relating to civil monetary penalties)
- 9.8.9. **X** Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10. **X** Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c))

The CHPlus program shall continue to involve the public in the design and implementation of the program, and ensures ongoing public involvement. The DOH has involved the Children's Defense Fund and Statewide Youth Advocacy groups on advisory committees. The DOH's Maternal and Child Health Program, as well as private sector advocacy groups, will continue to be involved in the multi-disciplinary approach to the program design and implementation.

9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

A financial form for the budget is being developed, with input from all interested parties, for States to utilize.

Premiums. Insurance premiums are reviewed and approved by the Commissioner of Health and the Superintendent of the New York State Insurance Department. For premium adjustments, the insurer shall be required to submit an application to DOH and the State Insurance Department for approval at least ninety (90) days prior to the requested effective date of such coverage.

In developing premium proposals, an insurer reflects adjustments for children under age one and pregnant women who shall be eligible for Medicaid coverage. Because of expanded Medicaid eligibility rules for children under age one and pregnant women, it is expected children under age one and pregnant women who are otherwise eligible for a State subsidy would be covered through the Medicaid program and not through the CHPlus program.

Premiums are paid to insurers on a uniform basis for all enrollees in designated geographical service areas.

Premium Payment to Insurers. CHPlus insurers are required to submit monthly billing information to the DOH. The files consist of individual records for each enrollee in the program for that month. The individual record includes such information as: the child's name, address, county, zip code, date of birth, effective date of coverage, and premium information.

In addition, insurers must also submit an original signed voucher when claiming payment. Monthly voucher bills shall be based on the actual number of children eligible for a subsidy enrolled in the program during the month for which payment is being claimed. All adjustments shall include a listing by enrollee of any change in enrollment occurring in that period.

Administration and Outreach allowance. No more than 10% of the annual total allotment shall be spent for expenditures for outreach activities and for other reasonable costs incurred by the State to administer the plan.

The following CHPlus budget description shall be updated periodically as necessary. The following State Fiscal year (SFY) time periods are described by this budget:

1999-2000	April 1, 1999 - March 31, 2000
2000-2001	April 1, 2000 - March 31, 2001
2001-2002	April 1, 2001 - March 31, 2002

I. Administrative Costs

A. Line Item Budget

Category	1999-2000	2000-2001	2001-2002
I. Salary and Fringe Benefit Cost			
A. Current Staff			
Personal Service	\$1,783,719	\$2,011,065	\$2,071,397
Fringe Benefits	\$527,981	\$595,275	\$613,133
<i>Subtotal Current Staff:</i>	\$2,311,700	\$2,606,340	\$2,684,530
B. Additional Staff			
Personal Service	\$1,490,400	\$1,680,361	\$1,730,772
Fringe Benefits	\$441,158	\$497,387	\$512,308
<i>Subtotal Current Staff:</i>	\$1,931,558	\$2,177,748	\$2,243,080
<i>Subtotal Salary and Fringe Benefit Cost:</i>	\$4,243,258	\$4,784,088	\$4,927,611
II. Indirect Cost	\$1,103,247	\$1,243,863	\$1,281,179
III. Contract Services	\$237,000	\$267,207	\$275,223
IV. Equipment	\$450,387	\$450,388	\$463,900
V. Supplies	\$148,800	\$167,315	\$172,334
VI. Travel	\$100,000	\$120,000	\$123,600
TOTAL ADMINISTRATIVE	\$6,282,693	\$7,032,861	\$7,243,847

B. Narrative

1. Current Staff Salary and Fringe Benefits

The personal service category reflects current CHPlus program staff and anticipated hiring of current vacant positions.

The fringe benefit rate for State employees is 29.6%. Fringe benefits include vacation accruals, retirement, health insurance, Social Security, Workers' Compensation, disability insurance and sick leave.

2. Additional Staff Salary and Fringe Benefits

To meet the demands of implementing the Federal program and the additional procurement processes which will be conducted, the Department is requesting additional positions.

Additional staff will be hired to assist current staff in providing:

- ! administration and executive direction;
- ! contract management;
- ! financial analysis;
- ! quality assurance, reporting and auditing;
- ! network analysis;
- ! procurement;
- ! health promotion;
- ! community outreach and marketing;
- ! health planning;
- ! analyses on special projects and routine correspondence;
- ! computer programming and Local Area Network (LAN) support;
- ! paraprofessional support; and
- ! secretarial/clerical assistance.

Based upon an average salary cost of \$48,000 per FTE, with a fringe benefit rate of 29.6%, the State is requesting \$1,931,558 for additional staffing for the federal CHPlus program in 1999-2000.

3. Indirect Cost

Indirect costs are calculated at 26% of total salaries, plus fringe benefits, of current project staff and additional project staff requested.

4. Contract Services

Contractual services will be required to facilitate meeting with contractors, insurers, hospitals

and other interested health care provider groups to perform the various duties necessary to implement and evaluate the CHPlus program, payment and billing systems.

5. Equipment

To accompany and assist increased staff, the Department will need to purchase personal computers and laser printers. In addition, equipment will be needed to expand the CHPlus local area network information system and develop data sets necessary to evaluate the progress of the program. A data base of information reported by the contractors will be developed and used to evaluate the impact of the program. New office furniture will also be purchased for new staff hired.

6. Supplies

Supply and materials funding is needed for purchases of general office supplies, electronic data processing (EDP) and word processing computer supplies, computer tables and chairs.

7. Travel

Travel is required to make on-site visits to validate eligibility and documentation in accordance with State and Federal legislative requirements. Travel is also required for the purpose of meeting with contractors, insurers, etc., to perform the various duties necessary to implement and evaluate the CHPlus program, payment and billing system.

II. Community Outreach and Marketing

A. Line Item Budget

Category	1999-2000	2000-2001	2001-2002
I. Current Community Outreach	\$250,000	\$250,000	\$250,000
II. Community Based Outreach	\$14,000,000	\$15,000,000	\$15,000,000
III. DOH Mass Media Campaign	\$4,302,373	\$5,717,139	\$5,700,000
TOTAL COMMUNITY OUTREACH AND MARKETING:	\$18,552,373	\$20,967,139	\$20,950,000

B. NARRATIVE

1. Current Community Outreach and Marketing Contract

A statewide allocation of \$250,000 per contract year is requested to be available to the current CHPlus Community Outreach contractor: *The New York Health Plan Association, formerly known as The HMO Council of New York / Comprehensive Prenatal-Perinatal Services Networks of New York (CPPSN) - "The HMO Council"*. The New York Health Plan Association (HMO Council) was chosen through a competitive procurement process in 1997.

DOH contracts with the New York Health Plan Association to design, implement and coordinate the statewide outreach and referral program. Specifically, the New York Health Plan Association will continue to be responsible for:

- ! Identification of the outreach and referral strategies/programs to be used to promote CHPlus. Examples of these activities and strategies include: presentations at community sites with the targeted population as the audience; outreach work coordinated among various community programs; visits to job training programs; and government assistance programs; interaction with the targeted population at health care sites; and linkages with schools.
- ! Identification of and contacts with community-based organizations, governmental agencies, media and individuals. Examples of these organizations are day care centers, schools, diagnostic and treatment centers, hospitals, county and city health departments, radio stations, local newspapers, and community leaders.
- ! Monitoring of the progress of the outreach strategies.

- ! Develop procedures to be used to refer parents and children to the CHPlus and Medicaid programs.
- ! Collect data and submit reports to the Department.
- ! Distribute brochures printed by the Department.
- ! Provision of technical assistance with the implementation of the outreach activities.
- ! Provide and maintain statewide telephone accessibility through an 800 number for potential CHPlus and/or Medicaid enrollees.
- ! Educate enrollees in the use of CHPlus as insurance coverage. Examples of this educational component where enrollees are oriented to the use of Child Health Plus benefits includes: informing the enrollee how to select a provider, how to make an appointment, what benefits are covered, how to obtain emergency care, and how to obtain care when outside the insurer's service area. Charges and payment procedures must also be explained.

2. Community Based Outreach

Community based outreach workers will be employed on a contracted basis and will be responsible for conducting promotion and enrollment for the CHPlus program on a statewide basis. Community based outreach workers will be based in community settings where there are a large number of uninsured children and will aid families in the enrollment process and help them access services. They will work with schools, medical providers and social service agencies in identifying uninsured children.

3. Department of Health Mass Media Campaign

The DOH Health Promotion Group will continue to conduct a multi-faceted mass market promotion plan for CHPlus. This program will include the production and printing of brochures, posters, television and magazine advertising, billboard campaigns, and use of the NYS referral hotline, Growing Up Healthy Hotline.

The Growing Up Healthy Hotline, a New York State sponsored referral service, is an 800 telephone number which refers callers to health and social programs. Child Health Plus is one of the options available to callers and many are referred to participating insurers and/or Medicaid.

III. Presumptive Eligibility for Title XXI

Costs for presumptive eligibility for Title XXI will be deducted from the 10% administration

and outreach allowance. CHPlus will continue to have a 60 day period of presumptive eligibility. If a family provides fraudulent information, they are responsible for the premium. However, if a family is unable to provide documentation of residency, income or age they are automatically disenrolled after 60 days. The cost of the premiums for these children will be deducted from the 10% outreach and administration reserved allotment. DOH experience with the current CHPlus program enables New York to project that approximately 20% of disenrollments are related to not meeting presumptive eligibility requirements.

**Presumptive Eligibility for Title XXI
Fiscal Impact of Sixty (60) Days of Presumptive Eligibility for Disenrolled Children**

Category	1999-2000	2000-2001	2001-2002
New (Net) Enrollment	41,900	27,400	43,600
Number of children disenrolled because they did not meet presumptive eligibility requirement	19,000	15,963	14,373
Sixty (60) day premium cost for disenrolled children	\$4,160,000	\$3,700,000	\$3,500,000

IV. Benefit Costs

Enrollment projections are based on current estimates of funds earmarked for the CHPlus program. The benefit costs shown below are only for the comprehensive CHPlus benefit package.

**New York Child Health Plus Program
Benefit Budget SFY 99-02**

Fiscal Year	Year End Enrollment	Average Annual Per Capita Cost	Total Cost *	Premium Offset	Total Net Cost
1999-2000	343,000	\$115.00	\$452,660,000	\$4,000,000	\$448,660,000
2000-2001	370,000	\$121.00	\$543,100,000	\$4,300,000	\$538,700,000
2001-2002	414,000	\$126.00	\$695,100,000	\$5,500,000	\$689,600,000

* The total costs were developed assuming an average monthly premium applied to an escalating monthly enrollment.

V. Non-Federal Share of State Expenditures

A. Legislative Authorization

Chapter 922 and 923 of the Laws of 1990 authorize the Commissioner of Health, in consultation with the Superintendent of Insurance, to establish a program to provide insurance for primary and preventive health care for children. The Commissioner of Health is also authorized to solicit plans for insurance contracts, to award contracts on the basis of Request for Proposal (RFP) process and to distribute funds from the Statewide Bad Debt and Charity Care Pool to provide for the cost of health care coverage of children under this program. Chapter 731 of the Laws of 1993 authorized continuation of this program through December 31, 1995, Chapter 81 of the Laws of 1995 authorized continuation of the program through June 30, 1996, and the Health Care Reform Act of 1996 continues the program through December 31, 1999, adds inpatient care as a covered benefit and expands the age limit to under 19 years.

B. Allocation and Funding

For the 1997-1999 calendar years, §2807-1(1)(a)(i)-(iii) of the New York Public Health Law (added by the Health Care Reform Act of 1996) authorized funds to be distributed from the Health Care Initiatives Pool for the Child Health Plus Program in the following amounts:

- (i) \$109 million - 1/1/97-12/31/97
- (ii) \$105 million - 1/1/98-12/31/98
- (iii) \$207 million - 1/1/99-12/31/99

New York State understands that there is a Maintenance of Effort requirement and will spend well over the \$71 million, which was the 1996 calendar year expenditure.

VI. Summary Budget

The following is a summary budget with estimated State and Federal share of spending for SFY 99-02.

No more than 10% of the annual total allotment shall be spent for expenditures for outreach activities and for other reasonable costs incurred by the State to administer the plan.

Category	Total	State Match	Federal Match
SFY 99-00: April 1, 1999 - March 31, 2000			
Administration, Outreach and Presumptive Eligibility Costs	\$28,995,066	\$10,148,273	\$18,846,793
Premium Costs	\$448,660,000	\$157,031,000	\$291,629,000
Total	\$477,655,066	\$167,179,273	\$310,475,793
SFY 00-01: April 1, 2000 - March 31, 2001			
Administration, Outreach and Presumptive Eligibility Costs	\$31,700,000	\$11,095,000	\$20,605,000
Premium Costs	\$538,700,000	\$188,545,000	\$350,155,000
Total	\$570,400,000	\$199,640,000	\$370,760,000
SFY 01-02: April 1, 2001 - March 31, 2002			
Administration, Outreach and Presumptive Eligibility Costs	\$31,693,847	\$11,092,846	\$20,601,001
Premium Costs	\$689,600,000	\$241,360,000	\$448,240,000
Total	\$721,293,847	\$252,452,846	\$468,841,001

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The State assures that it will assess the operation of the State plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2))

10.1.1. X The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.1.2. X Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

Below is a chart listing the types of information that the State’s annual report might include. Submission of such information will allow comparisons to be made between States and on a nationwide basis.

New York State will include all the following information in its annual report.

Attributes of Population	Number of Children with Creditable Coverage XIX OTHER CHPLUS	Number of Children without Creditable Coverage	TOTAL
Income Level:			
≤ 125%			
≤ 133%			
≤ 185%			
≤ 192%			
> 192%			
Age			
0 - 1			
1 - 5			
6 - 12			
13 - 18			

- 10.2. X State Evaluations. The State assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: (Section 2108(b)(A)-(H))**
- 10.2.1. X An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage.**
- 10.2.2. A description and analysis of the effectiveness of elements of the State plan, including:**
- 10.2.2.1. X The characteristics of the children and families assisted under the State plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the State plan and after eligibility for the State plan ends;**
 - 10.2.2.2. X The quality of health coverage provided including the types of benefits provided;**
 - 10.2.2.3. X The amount and level (including payment of part or all of any premium) of assistance provided by the State;**
 - 10.2.2.4. X The service area of the State plan;**
 - 10.2.2.5. X The time limits for coverage of a child under the State plan;**
 - 10.2.2.6. X The State's choice of health benefits coverage and other methods used for providing child health assistance, and**
 - 10.2.2.7. X The sources of non-Federal funding used in the State plan.**
- 10.2.3. X An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.**
- 10.2.4. X A review and assessment of State activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.**
- 10.2.5. X An analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.**
- 10.2.6. X A description of any plans the State has for improving the**

availability of health insurance and health care for children.

10.2.7. **X** Recommendations for improving the program under this Title.

10.2.8. **X** Any other matters the State and the Secretary consider appropriate.

10.3. **X** The State assures it will comply with future reporting requirements as they are developed.

10.4. **X** The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

APPENDIX I

NEW YORK STATE CHILD HEALTH PLUS BENEFITS PACKAGE

CHILD HEALTH PLUS BENEFITS PACKAGE
(No Pre-Existing Condition Limitations Permitted)

General Coverage	Scope of Coverage	Level of Coverage	Copayment/Deductible
Pediatric Health Promotion Visits	Well child care visits in accordance with visitation schedule established by American Academy of Pediatrics, and the New York State Department of Health recommended immunization schedule.	Includes all services related to visits. Includes immunizations, well child care, health education, tuberculin testing (mantoux), hearing testing, dental and developmental screening, clinical laboratory and radiological tests, eye screening, and lead screening.	No copayments or deductibles.

* New Benefit

** Clarification

General Coverage	Scope of Coverage	Level of Coverage	Copayment/Deductible
Inpatient Hospital Medical or Surgical Care	As a registered bed patient for treatment of an illness, injury or condition which cannot be treated on an outpatient basis. The hospital must be a short-term, acute care facility and New York State licensed.	No benefits will be provided for any out-of-hospital days, or if inpatient care was not necessary; no benefits are provided after discharge; benefits are paid in full for accommodations in a semi-private room. Includes 365 days per year coverage for inpatient hospital services and services provided by physicians and other professional personnel for covered inpatient services: bed and board, including special diet and nutritional therapy; general, special and critical care nursing services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care; oxygen and other inhalation therapeutic services and supplies; drugs and medications that are not experimental; sera, biologicals, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies; blood products, except when participation in a volunteer blood replacement program is available to the insured or covered person, and services and equipment related to their administration; facilities, services, supplies and equipment related to physical medicine and occupational therapy and rehabilitation; facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electro-encephalographic studies and examinations; facilities, services, supplies and equipment related to radiation and nuclear therapy; facilities, services, supplies and equipment related to emergency medical care; chemotherapy; any additional medical, surgical, or related services, supplies and equipment that customarily furnished by the hospital.	No copayments or deductibles.
Inpatient Mental Health and Alcohol and Substance Abuse Services*	Services to be provided in a facility operated by OMH under Sec. 7.17 of the Mental Hygiene Law, or a facility issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law or a general hospital as defined in Article 28 of the Public Health Law.	A combined 30 days per calendar year for inpatient mental health services, inpatient detoxification and inpatient rehabilitation.	No co-payments or deductibles

* New Benefit

** Clarification

General Coverage	Scope of Coverage	Level of Coverage	Copayment/Deductible
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.	No copayments or deductibles.*
Outpatient Surgery	Procedure performed within the provider's office will be covered as well as "ambulatory surgery procedures" which may be performed in a hospital-based ambulatory surgery service or a freestanding ambulatory surgery center.	The utilization review process must ensure that the ambulatory surgery is appropriately provided.	No copayments or deductibles.
Diagnostic and Laboratory Tests	Prescribed ambulatory clinical laboratory tests and diagnostic x-rays.	No limitations.	No copayments or deductibles.

* New Benefit

** Clarification

General Coverage	Scope of Coverage	Level of Coverage	Copayment/Deductible
<p>Durable Medical Equipment, Prosthetic Appliances and Orthotic Devices*</p>	<p><u>Durable Medical Equipment</u> means devices and equipment ordered by a practitioner for the treatment of a specific medical condition which</p> <ul style="list-style-type: none"> a) can withstand repeated use for a protracted period of time; b) are primarily and customarily used for medical purposes; c) are generally not useful in the absence of illness or injury; and d) 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><u>Prosthetic Appliances</u> are those appliances and devices ordered by a qualified practitioner which replace any missing part of the body.</p> <p><u>Orthotic Devices</u> 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.</p>	<p>Includes hospital beds and accessories, oxygen and oxygen supplies, pressure pads, volume ventilators, therapeutic ventilators, nebulizers and other equipment for respiratory care, traction equipment, walkers, wheelchairs and accessories, commode chairs, toilet rails, apnea monitors, patient lifts, nutrition infusion pumps, ambulatory infusion pumps and other miscellaneous DME.</p> <p>DME coverage includes equipment servicing (labor and parts).</p> <p>Covered without limitation except that 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.</p> <p>No limitations on orthotic devices except that devices prescribed solely for use during sports are not covered.</p>	<p>No Copayments or deductibles.</p>

* New Benefit

** Clarification

General Coverage	Scope of Coverage	Level of Coverage	Copayment/Deductible
Therapeutic Services.	<p>Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (i.e. chemotherapy) will also be covered.</p> <p>Hemodialysis</p>	<p>No limitations. These therapies must be medically necessary and under the supervision of referral of a licensed physician. Short term physical and occupational therapies will be covered when ordered by a physician. No procedure or services considered experimental will be reimbursed.</p> <p>Determination of the need for services and whether home based or facility based treatment is appropriate.</p>	No copayments or deductibles.
Speech and Hearing Services including hearing aids.*	Hearing examinations to determine the need for corrective action and speech therapy performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist.	<p>One hearing examination per calendar year is covered. Hearing aids, including batteries and repairs, are covered.</p> <p>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.</p>	No copayments or deductibles.
Pre-surgical Testing.	All tests (laboratory, x-ray, etc.) necessary prior to inpatient or outpatient surgery.	Benefits are available if a physician orders the tests; proper diagnosis and treatment require the tests; and the surgery takes place within seven days after the testing. If surgery is canceled because of pre-surgical test findings or as a result of a Second Opinion on Surgery, the cost of the tests will be covered.	No copayments or deductibles.
Second Surgical Opinion	Provided by a qualified physician.	No limitations.	No copayments or deductibles.
Second Medical Opinion.**	Provided by an appropriate specialist, including one affiliated with a specialty care center.	A second medical opinion is available in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation of a course of treatment of cancer.	No copayments or deductibles.
Outpatient visits for mental health and for the diagnosis and treatment of alcoholism and substance abuse.*	Services must be provided by certified and/or licensed professionals.	A combined 60 outpatient visits per calendar year. Visits may be for family therapy related to the alcohol or substance abuse.	No copayments or deductibles.

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General Coverage	Scope of Coverage	Level of Coverage	Copayment/Deductible
Home Health Care Services	The care and treatment of a covered person who is under the care of a physician but only if hospitalization or confinement in a skilled nursing facility would otherwise have been required if home care was not provided and the plan covering the home health service is established and provided in writing by such physician.	Home care shall be provided by a certified home health agency possessing a valid certificate of approval issued pursuant to article thirty-six of the public health law. Home care shall consist of one or more of the following: part-time or intermittent home health aide services which consist primarily of caring for the patient, physical, occupational, or speech therapy if provided by the home health agency and medical supplies, drugs and medications prescribed by a physician, and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered or provided under the contract if the covered person had been hospitalized or confined in a skilled nursing facility. The contact must provide forty such visits in any calendar year, if such visits are medically necessary.	No copayments or deductibles.
Prescription and Non-prescription Drugs.*	Prescription and non-prescription medications must be authorized by a professional licensed to write prescriptions.	Prescriptions must be medically necessary. May be limited to generic medications where medically acceptable. Includes family planning or contraceptive medications or devices. All medications used for preventive and therapeutic purposes will be covered. Vitamins are not covered except when necessary to treat a diagnosed illness or condition. Coverage includes enteral formulas for home use for which a physician or other provider authorized to prescribe has issued a written order. Enteral formulas for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein. Coverage for such modified solid food products shall not exceed \$2500 per calendar year.	No copayments or deductibles.

* New Benefit

** Clarification

General Coverage	Scope of Coverage	Level of Coverage	Copayment/Deductible
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> <p>(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, or</p> <p>(B) serious impairment to such person's bodily functions;</p> <p>(C) serious dysfunction of any bodily organ or part of such person; or</p> <p>(D) serious disfigurement of such person.</p>	No limitations.	No copayment or deductibles.

* New Benefit

** Clarification

General Coverage	Scope of Coverage	Level of Coverage	Copayment/Deductible
Maternity Care	Inpatient hospital coverage for at least 48 hours after childbirth for any delivery other than a C-Section and in at least 96 hours following a C-Section. Also coverage of parent education, assistance and training in breast and bottle feeding and any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the 48/96 hours, provided that at least one home care visit is covered post-discharge. Prenatal, labor and delivery care is covered.	No limitations; (however subsidized children requiring maternity care services will be referred to Medicaid).	No copayments or deductibles.
Diabetic Supplies and Equipment.	Coverage includes 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.	As prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law.	No copayments or deductibles.

* New Benefit

** Clarification

General Coverage	Scope of Coverage	Level of Coverage	Copayment/Deductible
Diabetic Education and Home Visits.	Diabetes self-management education (including diet); reeducation or refresher. Home visits for diabetic monitoring and/or education.	Limited to visits medically necessary where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management or where reeducation is necessary. May be provided by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified diagnosis nutritionist, certified dietician or registered dietician upon the referral of a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law and may be limited to group settings wherever practicable.	No copayments or deductibles.
Emergency, Preventive and Routine Vision Care.*	<p>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> <p>Prescribed Lenses</p> <p>Frames</p> <p>Contact Lenses</p>	<p>The vision examination may include, but is not limited to:</p> <ul style="list-style-type: none"> - case history - external examination of the eye and external or internal - 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 <p>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.</p> <p>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.</p> <p>Covered when medically necessary</p>	No copayments or deductibles.

* New Benefit

** Clarification

General Coverage	Scope of Coverage	Level of Coverage	Copayment/Deductible
Emergency, Preventive and Routine Dental Care.*	<p>Emergency Dental Care</p> <p>Preventive Dental Care</p> <p>Routine Dental Care</p> <p>Endodontics</p> <p>Prosthodontics</p>	<p>Includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.</p> <p>Includes procedures which help prevent oral disease from occurring, including but limited to:</p> <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. <p>- dental examinations, visits and consultations covered once within 6 consecutive period (when primary teeth erupt).</p> <p>- x-ray, full mouth x-rays at 36 month intervals, if necessary, bitewing x-rays at 6-12 month intervals, or panoramic x-rays at 36 month intervals if necessary; and other x-rays as required (once primary teeth erupt).</p> <p>- All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization including:</p> <ul style="list-style-type: none"> - preoperative care - postoperative care - In office conscious sedation - Amalgam, composite restorations and stainless steel crowns - Other restorative materials appropriate for children <p>Includes all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.</p> <p><u>Removable</u>: complete or partial dentures including six months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases.</p> <p><u>Fixed</u>: fixed bridges are not covered unless</p> <ol style="list-style-type: none"> 1) required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full 	No copayments or deductibles.

* New Benefit

** Clarification

General Coverage	Scope of Coverage	Level of Coverage	Copayment/Deductible
Emergency, Preventive and Routine Dental Care (continued)	Prosthodontics (continued)	<p>full complement of natural, functional and/or restored teeth; 2) required for cleft-palate stabilization; 3) required, as demonstrated by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis.</p> <p><u>Space Maintenance</u>: 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.</p> <p><u>NOTE</u>: Refer to the Medicaid Management Information System (MMIS) Dental Provider Manual for a more detailed description of services.</p>	No copayments or deductibles.

CHILD HEALTH PLUS EXCLUSIONS

The following services will not be covered:

- ☐ Experimental medical or surgical procedures.
- ☐ Experimental drugs.
- ☐ Drugs which can be bought without prescription, except as defined.
- ☐ Private duty nursing.
- ☐ Hospice services.
- ☐ 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 or rehabilitation 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.
- ☐ Personal or comfort items.
- ☐ Orthodontia Services.
- ☐ Services which are not medically necessary.