

New York CARTS FY2020 Report

Basic State Information

Welcome!

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

1. State or territory name:

New York

2.

Program type:

- Both Medicaid Expansion CHIP and Separate CHIP
- Medicaid Expansion CHIP only
- Separate CHIP only

3. CHIP program name(s):

All

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

4. Contact name:

New Yorker Name

5. Job title:

New Yorker Contact

6. Email:

contact@new.york.gov

7. Full mailing address:

Include city, state, and zip code.

Some New York address

8. Phone number:

Some New York phone number

PRA Disclosure Statement.

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

Program Fees and Policy Changes

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

1.

Does your program charge an enrollment fee?

Yes

No

2.

Does your program charge premiums?

Yes

No

3.

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

Yes

No

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

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

5.

Which delivery system(s) do you use?

Select all that apply.

Managed Care

Primary Care Case Management

Fee for Service

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

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

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

1.

Does your program charge an enrollment fee?

Yes

No

2.

Does your program charge premiums?

Yes

No

3.

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

Yes

No

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

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

5.

Which delivery system(s) do you use?

Select all that apply.

Managed Care

Primary Care Case Management

Fee for Service

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

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

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1.

Have you made any changes to the eligibility determination process?

- Yes
- No
- N/A

2.

Have you made any changes to the eligibility redetermination process?

Yes

No

N/A

3.

Have you made any changes to the eligibility levels or target populations?

For example: increasing income eligibility levels.

Yes

No

N/A

4.

Have you made any changes to the benefits available to enrollees?

For example: adding benefits or removing benefit limits.

Yes

No

N/A

5.

Have you made any changes to the single streamlined application?

Yes

No

N/A

6.

Have you made any changes to your outreach efforts?

For example: allotting more or less funding for outreach, or changing your target population.

Yes

No

N/A

7.

Have you made any changes to the delivery system(s)?

For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

Yes

No

N/A

8.

Have you made any changes to your cost sharing requirements?

For example: changing amounts, populations, or the collection process.

Yes

No

N/A

9.

Have you made any changes to the substitution of coverage policies?

For example: removing a waiting period.

Yes

No

N/A

10.

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

Yes

No

N/A

11.

Have you made any changes to the protections for applicants and enrollees?

For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

Yes

No

N/A

12.

Have you made any changes to premium assistance?

For example: adding premium assistance or changing the population that receives premium assistance.

Yes

No

N/A

13.

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

- Yes
- No
- N/A

14.

Have you made any changes to eligibility for "lawfully residing" pregnant women?

- Yes
- No
- N/A

15.

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

- Yes
- No
- N/A

16.

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

- Yes
- No
- N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

Changes were made to the Medicaid program as a result of the COVID-19 public health emergency. These changes also apply to the Medicaid expansion group. For example, cases, including those in the Medicaid expansion group, are being automatically extended at renewal. Individuals are also allowed to attest to their income for Medicaid during the public health emergency. The State has a concurrence letter from CMS outlining the Medicaid flexibilities. It was not a SPA.

18.

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

- Yes
- No
- N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the

past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1.

Have you made any changes to the eligibility determination process?

Yes

No

N/A

2.

Have you made any changes to the eligibility redetermination process?

Yes

No

N/A

3.

Have you made any changes to the eligibility levels or target populations?

For example: increasing income eligibility levels.

Yes

No

N/A

4.

Have you made any changes to the benefits available to enrollees?

For example: adding benefits or removing benefit limits.

Yes

No

N/A

5.

Have you made any changes to the single streamlined application?

Yes

No

N/A

6.

Have you made any changes to your outreach efforts?

For example: allotting more or less funding for outreach, or changing your target population.

Yes

No

N/A

7.

Have you made any changes to the delivery system(s)?

For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

Yes

No

N/A

8.

Have you made any changes to your cost sharing requirements?

For example: changing amounts, populations, or the collection process.

Yes

No

N/A

9.

Have you made any changes to substitution of coverage policies?

For example: removing a waiting period.

Yes

No

N/A

10.

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

Yes

No

N/A

11.

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

- Yes
- No
- N/A

12.

Have you made any changes to the protections for applicants and enrollees?

For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- Yes
- No
- N/A

13.

Have you made any changes to premium assistance?

For example: adding premium assistance or changing the population that receives premium assistance.

Yes

No

N/A

14.

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

Yes

No

N/A

15.

Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?

For example: expanding eligibility or changing this population's benefit package.

Yes

No

N/A

16.

Have you made any changes to your Pregnant Women State Plan expansion?

For example: expanding eligibility or changing this population's benefit package.

Yes

No

N/A

17.

Have you made any changes to eligibility for "lawfully residing" pregnant women?

Yes

No

N/A

18.

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

Yes

No

N/A

19.

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

Yes

No

N/A

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

New York has made several changes to its Separate CHIP program in response to the COVID-19 public health emergency. These changes were described in approved CHIP SPA, NY-20-0028 which provides temporary adjustments to policies related to application processing and renewals, the reasonable opportunity period and cost sharing requirements. Specifically, New York has implemented the following b" New York requested that timely processing requirements for applications and renewals be waived. New York is currently extending Child Health Plus cases at renewal for duration of the public health emergency. b" New York is providing an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status as long as the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period. b" New York is temporarily continuing coverage to children enrolled in Child Health Plus who fail to pay their family premium contribution. Changes have also been made to the way the program conducts outreach during the public health emergency, with more being done virtually. In the Spring of 2020, the Department and NY State of Health undertook an outreach campaign informing consumers to update their accounts if they experienced a change in circumstances such as losing their job as a result of COVID-19. The Department has also promoted the fact that changes and applications can be done by phone.

21.

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

Yes

No

Enrollment and Uninsured Data

Part 1: Number of Children Enrolled in CHIP

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

Program	Number of children enrolled in FFY 2019	Number of children enrolled in FFY 2020	Percent change
Medicaid Expansion CHIP	324,050	314,795	-2.856%
Separate CHIP	466,779	436,299	-6.53%

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

Enrollment in the separate CHIP program has declined since the COVID -19 public health emergency. During the pandemic, many families have experienced a change in circumstances such as a loss of employment or a reduction in hours, resulting in lower household income, making the child eligible for Medicaid.

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2015	61,000	6,000	1.4%	0.1%
2016	58,000	7,000	1.3%	0.2%
2017	57,000	7,000	1.3%	0.2%
2018	52,000	6,000	1.2%	0.1%
2019	44,000	5,000	1.1%	0.1%

Percent change between 2018 and 2019
Not Available

2.

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

Yes

No

3.

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

Yes

No

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

No.

5.

Optional: Attach any additional documents here.

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

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Browse...

Eligibility, Enrollment, and Operations

Program Outreach

1.

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

Yes

No

2.

Are you targeting specific populations in your outreach efforts?

For example: minorities, immigrants, or children living in rural areas.

Yes

No

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

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

The Department has found that local community partnerships have been a very effective way of reaching the target population. By engaging groups such as schools, health care providers, faith-based organizations, food pantries and other government entities, we are able to reach potentially eligible children and families that may not otherwise be reached. We measure the effectiveness by tracking the number of events, presentations and trainings and informational materials provided, as well as the number of applicants assisted by Navigators, Marketplace Facilitated Enrollers and Certified Application Counselors. The Department also believes that a coordinated outreach campaign is an effective strategy to reach low-income children and families. NY State of Health engages in a multi-faceted outreach campaign for all programs available on the Marketplace during the Open Enrollment Period. This includes a digital advertising campaign, print advertising and radio and television advertising built around a particular theme. These campaigns increase enrollment in all programs. NY State of Health also engaged in an outreach campaign at the start of the public health emergency to make sure individuals knew they could come in to apply for coverage if they had a change in circumstance. For example, a loss of employment or a reduction in hours. That campaign was successful in bringing new enrollment into the Marketplace. For Child Health Plus, families updated their accounts reflecting a reduction in income, sometimes transferring the child's coverage to Medicaid.

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

According to the 2019 American Community Survey, 97.03% of children below 200% FPL who are eligible for Medicaid or CHIP have been enrolled. This is up from 96.77% the year prior.

5.

Optional: Attach any additional documents here.

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

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Eligibility, Enrollment, and Operations

Substitution of Coverage

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

1.

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

Yes

No

N/A

2.

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

- Yes
- No
- N/A

07 %

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

No.

6.

Optional: Attach any additional documents here.

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

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Browse...

Eligibility, Enrollment, and Operations

Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1.

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

This question should only be answered in respect to Separate CHIP.

Yes

No

N/A

2.

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

Yes

No

3.

Do you send renewal reminder notices to families?

Yes

No

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

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

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

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

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

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

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

As previously noted, the Child Health Plus program has been automatically renewing children's coverage during the COVID-19 public health emergency. This temporary flexibility was included in approved CHIP SPA, NY-20-0028.

Part 2: CHIP Eligibility Denials (Not Redetermination)

1.

How many applicants were denied CHIP coverage in FFY 2020?

Don't include applicants being considered for redetermination - this data will be collected in Part 3.

8679

2.

How many applicants were denied CHIP coverage for procedural reasons?

For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

1789

3.

How many applicants were denied CHIP coverage for eligibility reasons?

For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

551

3a.

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

479

4.

How many applicants were denied CHIP coverage for other reasons?

72

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

No.

Table: CHIP Eligibility Denials (Not Redetermination)

This table is auto-populated with the data you entered above.

Type	Number	Percent
Total denials	8679	100%
Denied for procedural reasons	1789	20.61%
Denied for eligibility reasons	551	6.35%
Denials for other reasons	72	0.83%

Part 3: Redetermination in CHIP

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

1.

How many children were eligible for redetermination in CHIP in FFY 2020?

231462

2.

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

231462

3.

How many children were retained in CHIP after redetermination?

193750

4.

How many children were disenrolled in CHIP after the redetermination process?

This number should be equal to the total of 4a, 4b, and 4c below.

37712

Computed: 37712

4a.

How many children were disenrolled for procedural reasons?

This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

1789

4b.

How many children were disenrolled for eligibility reasons?

This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

10100

4c.

How many children were disenrolled for other reasons?

25823

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

No.

Table: Redetermination in CHIP

These tables are auto-populated with the data you entered above.

Type	Number	Percent
Children screened for redetermination	231462	100%
Children retained after redetermination	193750	83.71%
Children disenrolled after redetermination	37712	16.29%

Table: Disenrollment in CHIP after Redetermination

Type	Number	Percent
Children disenrolled after redetermination	37712	100%
Children disenrolled for procedural reasons	1789	4.74%
Children disenrolled for eligibility reasons	10100	26.78%
Children disenrolled for other reasons	25823	68.47%

Part 4: Redetermination in Medicaid

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

1.

How many children were eligible for redetermination in Medicaid in FFY 2020?

2.

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

3.

How many children were retained in Medicaid after redetermination?

4.

How many children were disenrolled in Medicaid after the redetermination process?

This number should be equal to the total of 4a, 4b, and 4c below.

Computed:

4a.

How many children were disenrolled for procedural reasons?

This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b.

How many children were disenrolled for eligibility reasons?

This could be due to an income that was too high and/or eligibility in CHIP instead.

4c.

How many children were disenrolled for other reasons?

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

Part 4 was intentionally left blank.

Table: Redetermination in Medicaid

These tables are auto-populated with the data you entered above.

Type	Number	Percent
Children screened for redetermination	Not Answered	Not Answered
Children retained after redetermination	Not Answered	Not Answered
Children disenrolled after redetermination	Not Answered	Not Answered

Table: Disenrollment in Medicaid after Redetermination

Type	Number	Percent
Children disenrolled after redetermination	Not Answered	Not Answered
Children disenrolled for procedural reasons	Not Answered	Not Answered
Children disenrolled for eligibility reasons	Not Answered	Not Answered
Children disenrolled for other reasons	Not Answered	Not Answered

Part 5: Tracking a CHIP cohort (Title XXI) over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.

To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.

You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2021) and 18 months later (July - Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups

Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1.

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

Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP in December 2019.

Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2.

Do you have data for individual age groups?

If not, you'll report the total number for all age groups (0-16 years) instead.

Yes

No

January - March 2020 (start of the cohort)

3.

How many children were newly enrolled in CHIP between January and March 2020?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

2314

20643

26829

15082

July - September 2020 (6 months later)

4.

How many children were continuously enrolled in CHIP six months later?

Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

1902

16193

21569

12322

5.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

48

484

603

337

6.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

1

18

14

8

7.

How many children were no longer enrolled in CHIP six months later?

Possible reasons for no longer being enrolled:

b" Transferred to another health insurance program other than CHIP

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

364

3966

4657

2424

8.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

274

3184

3837

2113

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

For questions 3-5 and 7 the New York State Knowledge, Information and Data System (KIDS) was used as the data source. For questions 6 and 8 the New York State of Health Marketplace was used as the data source as KIDS is unable to track children across the CHIP and MA populations.

January - March 2021 (12 months later)

Next year you'll report this data. Leave it blank in the meantime.

10.

How many children were continuously enrolled in CHIP 12 months later?

Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

11.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

12.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

13.

How many children were no longer enrolled in CHIP 12 months later?

Possible reasons for not being enrolled:

b" Transferred to another health insurance program other than CHIP

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

14.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

July - September of 2021 (18 months later)

Next year you'll report this data. Leave it blank in the meantime.

15.

How many children were continuously enrolled in CHIP 18 months later?

Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

16.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

17.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

18.

How many children were no longer enrolled in CHIP 18 months later?

Possible reasons for not being enrolled:

b" Transferred to another health insurance program other than CHIP

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

19.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

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

No.

Part 6: Tracking a Medicaid (Title XIX) cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.

To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.

You'll identify a new cohort every two years. This year you'll report the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2021) and 18 months later (July-Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups

Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1.

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

Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in Medicaid in December 2019.

Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2.

Do you have data for individual age groups?

If not, you'll report the total number for all age groups (0-16 years) instead.

Yes

No

January - March 2020 (start of the cohort)

3.

How many children were newly enrolled in Medicaid between January and March 2020?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

0

0

27236

10173

July - September 2020 (6 months later)

4.

How many children were continuously enrolled in Medicaid six months later?

Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

5.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

6.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

7.

How many children were no longer enrolled in Medicaid six months later?

Possible reasons for no longer being enrolled:

b" Transferred to another health insurance program other than Medicaid

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

0

0

2701

913

8.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

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

Question 6 and 8 were intentionally left blank, as data is unavailable at this time.

January - March 2021 (12 months later)

Next year you'll report this data. Leave it blank in the meantime.

10.

How many children were continuously enrolled in Medicaid 12 months later?

Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

11.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

12.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

13.

How many children were no longer enrolled in Medicaid 12 months later?

Possible reasons for not being enrolled:

b" Transferred to another health insurance program other than Medicaid

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

14.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

July - September of 2021 (18 months later)

Next year you'll report this data. Leave it blank in the meantime.

15.

How many children were continuously enrolled in Medicaid 18 months later?

Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

16.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

17.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

18.

How many children were no longer enrolled in Medicaid 18 months later?

Possible reasons for not being enrolled:

b" Transferred to another health insurance program other than Medicaid

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

19.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

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

Regarding Part 1a and 1b questions that were left blank, we are currently not tracking the children who are enrolling without documentation but we will look to try to do that for the future. Regarding the questions that were left blank in Part 4, Part 5 and Part 6 of this section - these questions are in regard to the MCHIP population which we will look to try and provide data for in the future.

Eligibility, Enrollment, and Operations

Cost Sharing (Out-of-Pocket Costs)

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

1.

Does your state require cost sharing?

Yes

No

2.

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

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

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

N/A

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

N/A

5.

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

Yes

No

6.

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

Yes

No

7. You indicated in Section 1 that you changed your cost sharing requirements in the past federal fiscal year. How are you monitoring the impact of these changes on whether families apply, enroll, disenroll, and use CHIP health services? What have you found when monitoring the impact?

N/A

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

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

9.

Optional: Attach any additional documents here.

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

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Eligibility, Enrollment, and Operations

Employer Sponsored Insurance and Premium Assistance

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

1.

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

Yes

No

Eligibility, Enrollment, and Operations

Program Integrity

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

1.

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

Yes

No

2.

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

Yes

No

3.

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

Yes

No

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

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

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

5.

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

- Yes
- No
- N/A

6.

How many eligibility denials have been appealed in a fair hearing in FFY 2020?

621

7.

How many cases have been found in favor of the beneficiary in FFY 2020?

312

8.

How many cases related to provider credentialing were investigated in FFY 2020?

3

9.

How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2020?

2

10.

How many cases related to provider billing were investigated in FFY 2020?

1348

11.

How many cases were referred to appropriate law enforcement officials in FFY 2020?

236

12.

How many cases related to beneficiary eligibility were investigated in FFY 2020?

7

13.

How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2020?

7

14.

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

- CHIP only
- Medicaid and CHIP combined

15.

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

- Yes
- No

16.

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

- Yes
- No

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

No.

18.

Optional: Attach any additional documents here.

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

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Eligibility, Enrollment, and Operations

Dental Benefits

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

Note on age groups

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

1.

Do you have data for individual age groups?

If not, you'll report the total number for all age groups (0-18 years) instead.

Yes

No

2.

How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2020?

Ages 0-1

Ages 1-2

Ages 3-5

Ages 6-9

Ages
10-14

Ages
15-18

9652

38731

70376

98423

125569

97441

3.

How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2020?

Ages 0-1

Ages 1-2

Ages 3-5

Ages 6-9

Ages
10-14

Ages
15-18

413

10276

35645

57508

65367

41259

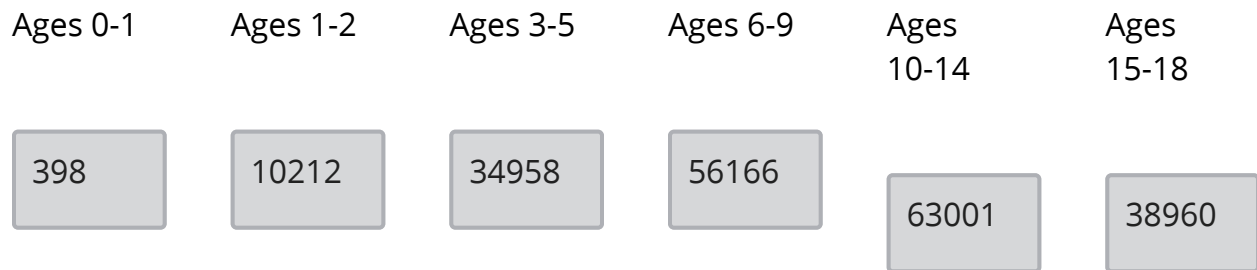
Dental care service codes and definitions

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

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

4.

How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2020?



Dental care service codes and definitions

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

5.

How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2020?

This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
62	1039	10781	24397	25361	17974

Dental treatment service codes and definitions

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

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

6.

How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2020?

12273

Sealant codes and definitions

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

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

7.

Do you provide supplemental dental coverage?

Yes

No

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

No.

9.

Optional: Attach any additional documents here.

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Eligibility, Enrollment, and Operations

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction.

1.

Did you collect the CAHPS survey?

Yes

No

Part 2: You collected the CAHPS survey

Since you collected the CAHPS survey, please complete Part 2.

1.

Upload a summary report of your CAHPS survey results.

This is optional if you already submitted CAHPS raw data to the AHRQ CAHPS database. Submit results only for the CHIP population, not for both Medicaid (Title XIX) and CHIP (Title XXI) together. Your data should represent children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

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

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

2.

Which CHIP population did you survey?

- Medicaid Expansion CHIP
- Separate CHIP
- Both Separate CHIP and Medicaid Expansion CHIP
- Other

3.

Which version of the CAHPS survey did you use?

- CAHPS 5.0
- CAHPS 5.0H
- Other

4.

Which supplemental item sets did you include in your survey?

Select all that apply.

- None
- Children with Chronic Conditions
- Other

4a. Which supplemental item sets did you include?

We included rating of child's treatment or counseling. We included three items from the CAHPS health information technology item set: getting timely appointments through e-mail or website, getting timely answers to medical questions by e-mail, and helpfulness of provider's website in giving you information about your care and tests.

5.

Which administrative protocol did you use to administer the survey?

Select all that apply.

NCQA HEDIS CAHPS 5.0H

HRQ CAHPS

Other

6. Is there anything else you'd like to add about your CAHPS survey results?

New York administered the CAHPS 5.0 Medicaid Child survey with the Children Chronic Condition module with managed care plans involved with Medicaid and Child Health Plus members. The survey is conducted on a biennial basis and was last administered from October 2018 to January 2019. Highlights from the last administered survey include: b"In general, families with children with self-reported chronic conditions are more satisfied than families with children without chronic conditions, which is consistent with the 2018 survey results. b"Compared 2016, improvement has been seen across many measures including coordination of care among different providers o services, getting special therapy, discussing prevention of illness, and the rating of all child's health care. b"The areas that may have opportunities to improve include communication items like access to specialized services, getting care needed, and communication.

Part 3: You didn't collect the CAHPS survey

Eligibility, Enrollment, and Operations

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.

States can use up to 10% of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act.] States can only develop HSI programs after funding other costs to administer their CHIP State Plan, as defined in regulations at 42 CFR 457.10.

1.

Does your state operate Health Service Initiatives using CHIP (Title XXI) funds?

Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

Yes

No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

Poison Control Center Part 1: New York City Poison Control Center (NYCPCC)

2.

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

Yes

No

3. Which populations does the HSI program serve?

Children < 19 years of age in NYC, Nassau, Suffolk and Westchester counties.

4.

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

31145

5.

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

12458

Computed: 40%

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

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

We look at mapping for health disparities (crowding, poverty, language) and then we measure targeted outreach efforts in each of the identified zip codes.

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

Although we have been successful, there is a continued need to expand collaboration with community leaders and governmental agencies serving these populations.

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

The poison center has shown it's relevance especially during the COVID pandemic by providing a resource to address questions about COVID, questions about varied treatments for COVID, assisting with medication safety, and intentional and unintentional exposures. By having our service available (24/7) we were able to focus on keeping patients out of the hospital when it was not necessary. Our program is a phone service that is free of charge and is available to all residents of our catchment area regardless of the callers ability to pay or social status.

9.

Optional: Attach any additional documents.

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

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

1. What is the name of your HSI program?

Poison Control Center Part 2: Upstate New York Poison Center

2.

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

Yes

No

3. Which populations does the HSI program serve?

Children < 19 years of age in NYS, outside of NYC, Nassau, Suffolk and Westchester counties.

4.

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

24208

5.

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

6052

Computed: 25%

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

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

Utilization of our Poison Center. Awareness of services. ED utilization.

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

Increase in call volume. Lack of awareness around poison centers, high refugee population not comfortable or aware of what services are provided. Decrease in unnecessary ED utilization.

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

Refinement to our initiatives is based on ongoing needs assessment within our catchment area and close review of the data.

9.

Optional: Attach any additional documents.

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

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

1. What is the name of your HSI program?

Sickle Cell Disease Program

2.

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

Yes

No

3. Which populations does the HSI program serve?

Children, Adolescence, and Young Adults ages 12-21 with Sickle Cell Disease who are served to successful complete a transition readiness assessment from pediatric to adult care.

4.

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

484

5.

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

0

Computed: 0%

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

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

1) Number of individuals ages 14-21 who had an initial transition readiness assessment completed 2) Number of individuals ages 14-21 who completed a transition readiness assessment: 295 individuals

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

1) 118 individuals ages 14-21 completed an initial transition readiness assessment
2): 295 individuals ages 14-21 completed a transition readiness assessment

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

The COORDINATING CARE & SUPPORTING TRANSITION FOR CHILDREN AND ADOLESCENTS AND YOUNG ADULTS (AYA) WITH SICKLE CELL DISEASE program contracts with three New York State Hemoglobinopathy Centers using state appropriations in the enacted budget. The program goal is to reduce morbidity and mortality in children/AYA with Sickle Cell Disease during transition from pediatric care to adult/self-care.

9.

Optional: Attach any additional documents.

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

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

1. What is the name of your HSI program?

Hunger Prevention and Nutrition Assistance Program (HPNAP)

2.

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

Yes

No

3. Which populations does the HSI program serve?

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

4.

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

64000000

5.

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

64000000

Computed: 100%

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

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

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

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

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

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

At the time of the initial 2020 CART report submission program did not have a full years' worth of data and reported 64 million meals. Now the program has an updated figure of 97 million meals were served to children during FFY 2020. This works out to be 8 million meals per month. Please note the information provided is for the number meals served to children only.

9.

Optional: Attach any additional documents.

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

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

1. What is the name of your HSI program?

Opioid Drug Addiction and Opioid Overdose Prevention Programs for Schools

2.

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

Yes

No

3. Which populations does the HSI program serve?

Secondary school aged children in school districts which have naloxone on premises to respond to opioid overdoses.

4.

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

313699

5.

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

138799

Computed: 44.25%

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

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

Metric 1: Number of school districts and schools with onsite opioid overdose response capacity. Metric 2: Number of school-based personnel trained in opioid overdose response, including being able to administer naloxone.

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

Outcome 1: There are 98 school districts, 9 Board of Cooperative Educational Services districts and 1 private secondary school which currently have registrations with NYSDOH to conduct opioid overdose prevention programs. These registrations cover 456 distinct schools. All of these schools have naloxone and trained personnel. Outcome 2: In FFY 2019-20 (Oct 2019 to Sept 2020), 4,067 school personnel were trained in overdose response and have access to naloxone.

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

New York State's Opioid Overdose Prevention Program for Schools initiative arose from a collaboration between NYSDOH and the State Education Department (SED) in 2015. It is part of a larger NYSDOH overdose initiative dating back to 2006 in which eligible entities register as Opioid Overdose Prevention Programs to train community responders in recognizing and responding to opioid overdoses through the administration of naloxone, the medication that reverses these overdoses. NYSDOH furnishes naloxone to registered programs. Of the more than 825 programs registered as of December 1, 2020, 108 are based in secondary schools. The number of children estimated to be served by this initiative is based on the total enrollment in these school districts; and the number of children served by this HSI program below 400% of the FPL is derived from SED data on students who are economically disadvantaged. These data are available SED's Information and Reporting Services (IRS) portal at: <http://www.p12.nysed.gov/irs/statistics/enroll-n-staff/home.html>. Economic disadvantage is defined as follows: Economically disadvantaged students are those who participate in, or whose family participates in, economic assistance programs, such as the free or reduced-price lunch programs, Social Security Insurance (SSI), Food Stamps, Foster Care, Refugee Assistance (cash or medical assistance), Earned Income Tax Credit (EITC), Home Energy Assistance Program (HEAP), Safety Net Assistance (SNA), Bureau of Indian Affairs (BIA), or Family Assistance: Temporary Assistance for Needy Families (TANF). If one student in a family is identified as low income, all students from that household (economic unit) may be identified as low income. The 98 school districts represents the total number of school districts which have current opioid overdose prevention program registrations. It is not in addition to the 105 districts in the prior year. Registrations are only for two years-and some school districts' registrations lapse without renewal. Very often this is because a school district has already obtained what it needs-naloxone-or it has formed a relationship with another registered program, such as a local health department, and thus has no need to continue to remain registered in its own right. In addition to the 98 school districts, there are also 9 Board of Cooperative Educational Services districts and 1 private secondary school which currently have registrations with NYSDOH to conduct opioid overdose prevention programs

9.

Optional: Attach any additional documents.

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

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Do you have another in this list?

Optional

State Plan Goals and Objectives

Part 1: Tell us about your goals and objectives

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

Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal for this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of eligible children in the CHIP program.

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

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

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

Rate of uninsured children under 400% FPL in New York State in most current survey year.

4.

Numerator (total number)

2.82

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

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

6.

Denominator (total number)

3.01

Computed: 93.69%

7.

What is the date range of your data?

Start

mm/yyyy

01 / 2018

End

mm/yyyy

12 / 2019

8.

Which data source did you use?

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

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

N/A this is a new goal.

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

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

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

No.

12.

Do you have any supporting documentation?

Optional

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

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Do you have another in this list?

Optional

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

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

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

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

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

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

Children between 6-12 years of age with a new prescription for ADHD medication, who remained on the medication for 120 days, and had at least two follow up visits with a practitioner 9 months after initiation phase.

4.

Numerator (total number)

2576

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

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

6.

Denominator (total number)

3824

Computed: 67.36%

7.

What is the date range of your data?

Start

mm/yyyy

03 / 2018

End

mm/yyyy

02 / 2019

8.

Which data source did you use?

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

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

N/A this is a new goal.

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

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

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

No.

12.

Do you have any supporting documentation?

Optional

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

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Browse...

Do you have another in this list?

Optional

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

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

Increase the use of preventative care.

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

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

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

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

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

4.

Numerator (total number)

2748

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

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

6.

Denominator (total number)

6082

Computed: 45.18%

7.

What is the date range of your data?

Start

mm/yyyy

01 / 2018

End

mm/yyyy

12 / 2018

8.

Which data source did you use?

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

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

N/A this is a new goal.

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

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

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

No.

12.

Do you have any supporting documentation?

Optional

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

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Do you have another in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

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

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

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

While there are no new plans currently for measuring and reporting on our goals and objectives we are evaluating our reporting schedule in light of COVID-19 impacts and will update if major timelines change.

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

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

4.

Optional: Attach any additional documents here.

For example: studies, analyses, or any other documents that address your performance goals.

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

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Program Financing

Tell us how much you spent on your CHIP program in FFY 2020, and how much you

anticipate spending in FFY 2021 and 2022.

Part 1: Benefit Costs

Please type your answers in only. Do not copy and paste your answers.

1.

How much did you spend on Managed Care in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 773,480,000

\$ 796,684,000

\$ 820,585,000

2.

How much did you spend on Fee for Service in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 773,480,000

\$ 796,684,000

\$ 820,585,000

3.

How much did you spend on anything else related to benefit costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 0

\$ 0

\$ 0

4.

How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 1,020,057,000

\$ 1,050,659,000

\$ 1,082,170,000

Table 1: Benefits Costs

This table is auto-populated with the data you entered above.

Type	FFY 2020	FFY 2021	FFY 2022
Managed Care	773480000	796684000	820585000
Fee for Service	0	0	0
Other benefit costs	1020057000	1050659000	1082170000
Cost sharing payments from beneficiaries	76224000	77000000	77000000
Total benefit costs	1869761000	1924343000	1979755000

Part 2: Administrative Costs

Please type your answers in only. Do not copy and paste your answers.

1.

How much did you spend on personnel in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

This includes wages, salaries, and other employee costs.

2020

2021

2022

\$ 0

\$ 0

\$ 0

2.

How much did you spend on general administration in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 180,864,729

\$ 29,794,226

\$ 30,688,053

3.

How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 0

\$ 0

\$ 0

4.

How much did you spend on claims processing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 0

\$ 0

\$ 0

5.

How much did you spend on outreach and marketing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 2,691,198

\$ 2,771,934

\$ 2,855,092

6.

How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 5,184,355

\$ 164,138,617

\$ 169,319,521

7.

How much did you spend on anything else related to administrative costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 0

\$ 0

\$ 0

Table 2: Administrative Costs

This table is auto-populated with the data you entered above.

Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

Type	FFY 2020	FFY 2021	FFY 2022
Personnel	0	0	0
General administration	180864729	29794226	30688053
Contractors and brokers	0	0	0
Claims processing	0	0	0
Outreach and marketing	2691198	2771934	2855092
Health Services Initiatives (HSI)	5184355	164138617	169319521
Other administrative costs	0	0	0
Total administrative costs	188740282	196704777	202862666
10% administrative cap	190812555.56	196704777.78	202861666.67

Table 3: Federal and State Shares

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

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

Type	FFY 2020	FFY 2021	FFY 2022
Total program costs	2058501282	2121047777	2182617666
eFMAP	76.5	65	65
Federal share	1574753480.73	1378681055.05	1418701482.9
State share	483747801.27	742366721.95	763916183.1

8.

What were your state funding sources in FFY 2020?

Select all that apply.

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

9.

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

- Yes
- No

Part 3: Managed Care Costs

Complete this section only if you have a Managed Care delivery system.

1.

How many children were eligible for Managed Care in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020

2021

2022

531600

547500

563900

2.

What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?

Round to the nearest whole number.

2020

2021

2022

\$ 233

\$ 234

\$ 235

Type	FFY 2020	FFY 2021	FFY 2022
Eligible children	531600	547500	563900
PMPM cost	233	234	235

Part 4: Fee for Service Costs

Complete this section only if you have a Fee for Service delivery system.

1.

How many children were eligible for Fee for Service in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020

2021

2022

2.

What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?

The per member per month cost will be the average cost per month to provide services to these enrollees. Round to the nearest whole number.

2020

2021

2022

Type	FFY 2020	FFY 2021	FFY 2022
Eligible children	0	0	0
PMPM cost	0	0	0

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

No.

2.

Optional: Attach any additional documents here.

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

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

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Challenges and Accomplishments

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

Despite the current fiscal crisis New York State is experiencing, Governor Cuomo continues to show his support and commitment to ensuring all children and adults have access to affordable, high quality health insurance through NY State of Health, New York's Health Plan Marketplace.

2. What's the greatest challenge your CHIP program has faced in FFY 2020?

The greatest challenge New York's CHIP program has faced during FFY 2020 is the COVID-19 public health emergency. During this challenging period, the priority for the Child Health Plus program is to ensure that children obtain coverage and remain insured during the pandemic.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2020?

The greatest accomplishment New York's CHIP program experienced in FFY 2020 was developing and implementing its disaster relief provisions due to COVID-19.

4. What changes have you made to your CHIP program in FFY 2020 or plan to make in FFY 2021? Why have you decided to make these changes?

In FFY 2020, New York's CHIP program implemented temporary adjustments to programmatic rules to ensure that children remain enrolled during the COVID-19 public health emergency. Renewals have been extended to ensure that children remain enrolled, additional time has been allowed for families to submit documentation in support of their application and children remain enrolled if they fail to pay the required premium contribution. In accordance with approved CHIP SPA NY-20-0028, these provisions will remain in effect for the duration of the public health emergency. In FFY 2021, New York will be implementing systems changes in NY State of Health to remove the waiting period for children with income between 250% and 400% of the federal poverty level who voluntarily dropped employer sponsored health insurance within the past three months and did not meet one of the waiting period exceptions. Currently, these cases are manually adjusted so that children do not experience a waiting period before enrolling in Child Health Plus.

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

No.

6.

Optional: Attach any additional documents here.

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

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