New York CARTS FY2021 Report

Basic State Information

Welcome!

We already have some information about your state from our records. If any information is incorrect, please contact the mdct_help@cms.hhs.gov.

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):

Child Health Plus

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

4. Contact name:

Erin Chaskey

5. Job title:

Health Program Administrator 2

6. Email:

erin.chaskey@health.ny.gov

7. Full mailing address:

Include city, state, and zip code.

One Commerce Plaza Albany, NY 12210

8. Phone number:

518-473-0566

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 223-250% 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

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 enrolees?

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.

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

◉   Yes

○   No

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

Flexibilities made to the Separate CHIP program, Child Health Plus, as outlined in approved CHIP SPA NY-20-0028, remain in effect as a result of the extension of the COVID 19 public health emergency. The waiting period for children with household income between 250 and 400% of the federal poverty level who voluntarily dropped employer sponsored health insurance coverage within the past three months and did not meet one of the waiting period exceptions was removed from NY State of Health, New York's health plan marketplace, on July 15, 2021. As a result of this change, the manual process remove children from the waiting period is no longer required.

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 2020	Number of children enrolled in FFY 2021	Percent change
Medicaid Expansion CHIP	163,381	0	-100%
Separate CHIP	161,637	0	-100%

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

Please note, New York's SEDS data is not populating in CARTS so the data has been entered in the attached table. The number of children ever enrolled in both the Medicaid Expansion and Separate CHIP program populations declined in FFY 2021. During the public health emergency, under the FFCRA and NY CHIP SPA 20-0028, children are not required to renew their coverage annually but rather, coverage is being extended for both CHIP and Medicaid, likely resulting in a lower overall unduplicated CHIP enrollment. In addition, Child Health Plus enrollees who fail to pay their family premium contribution remain enrolled in coverage. Under normal circumstance, children who lose coverage due to failure to renew or pay their premium are required to reapply. As a result, children may report changes in circumstances resulting in them moving between programs when they reapply and increasing overall unduplicated CHIP enrollment. While families continue to report changes in circumstances during the public health emergency, it is likely not at the same level as if every child is renewing their coverage annually. We also believe the FFY 2020 numbers were somewhat higher due to the fact there were normal enrollment rules during six months of the year and easements due to the public health emergency for the remainder of the year.

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. Due to the impacts of the COVID-19 PHE on collection of ACS data, the 2020 children's uninsurance rates are currently unavailable. Please skip to Question 3.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
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%
2020	Not Answered	Not Answered	Not Answered	Not Answered

Percent change between 2019 and 2020
Not Available

1. What are some reasons why the number and/or percent of uninsured children has changed?

Due to the impacts of the COVID-19 PHE on collection of ACS data, the 2020 ACS utilized an experimental estimation methodology and should not be compared to any other ACS year.

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?

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)

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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

.37	%

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)

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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. New York is exploring ways to expand the percentage of consumers who administratively renew once the PHE ends.

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. During the PHE assistors continue to reach out to their clients to help them in reporting changes,

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 continues to automatically renew 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 2021?

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

5400

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.

289

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.

401

3a.

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

357

4.

How many applicants were denied CHIP coverage for other reasons?

44

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	5400	100%
Denied for procedural reasons	289	5.35%
Denied for eligibility reasons	401	7.43%
Denials for other reasons	44	0.81%

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 2021?

0

2.

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

0

3.

How many children were retained in CHIP after redetermination?

0

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.

0

Computed: 0

4a.

How many children were disenrolled for procedural reasons?

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

0

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.

0

4c.

How many children were disenrolled for other reasons?

0

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

As previously discussed NY CHIP enrollees have been extended at their renewal during the PHE, in accordance with our approved CHIP SPA NY-20-0028.

Table: Redetermination in CHIP

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

Type	Number	Percent
Children screened for redetermination	0	Not Answered
Children retained after redetermination	0	Not Answered
Children disenrolled after redetermination	0	Not Answered

Table: Disenrollment in CHIP after Redetermination

Type	Number	Percent
Children disenrolled after redetermination	0	Not Answered
Children disenrolled for procedural reasons	0	Not Answered
Children disenrolled for eligibility reasons	0	Not Answered
Children disenrolled for other reasons	0	Not Answered

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 2021?

0

2.

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

0

3.

How many children were retained in Medicaid after redetermination?

0

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.

> 0

Computed: 0

4a.

How many children were disenrolled for procedural reasons?

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

> 0

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.

> 0

4c.

How many children were disenrolled for other reasons?

0

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

Because of the COVID-19 public health emergency New York has not completed redeterminations in Medicaid due to the FFCRA requirement to not disenroll consumers from Medicaid.

Table: Redetermination in Medicaid

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

Type	Number	Percent
Children screened for redetermination	0	Not Answered
Children retained after redetermination	0	Not Answered
Children disenrolled after redetermination	0	Not Answered

Table: Disenrollment in Medicaid after Redetermination

Type	Number	Percent
Children disenrolled after redetermination	0	Not Answered
Children disenrolled for procedural reasons	0	Not Answered
Children disenrolled for eligibility reasons	0	Not Answered
Children disenrolled for other reasons	0	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 last year you reported on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). This year you'll report on 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): included in 2020 report.

You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

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): included in 2020 report.

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 CHIPb" Didn't meet eligibility criteria anymoreb" Didn't complete documentationb" Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
364	3966	4657	2423

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): to be completed this year.

This year, please report data about your cohort for this section

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
1621	13942	18896	10733

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
78	563	761	417

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
3	32	37	24

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 CHIPb" Didn't meet eligibility criteria anymoreb" Didn't complete documentationb" Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
615	6138	7172	3932

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
392	4902	5817	3177

July - September of 2021 (18 months later): to be completed this year

This year, please report data about your cohort for this section.

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
1486	12583	17429	10079

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
102	652	876	483

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
9	52	61	33

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 CHIPb" Didn't meet eligibility criteria anymoreb" Didn't complete documentationb" Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
726	7408	8524	4520

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
427	5644	6669	3677

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

For questions 10-11,13,15-16,18 the New York State Knowledge, Information and Data System (KIDS) was used as the data source. For questions 12,14,17,19, 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.

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 last year you reported the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). This 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 2021. 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 2021 must be born after January 2004. Similarly, children who are newly enrolled in February 2021 must be born after February 2004, and children newly enrolled in March 2021 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): included in 2020 report

You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

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
		27236	10173

July - September 2020 (6 months later): included in 2020 report

You completed this section in your 2020 CARTS report. Please refer to that report to assist in filling out this section if needed.

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
		24103	9102

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
		432	158

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 Medicaidb" Didn't meet eligibility criteria anymoreb" Didn't complete documentationb" Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
		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?

January - March 2021 (12 months later): to be completed this year

This year, please report data about your cohort for this section.

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
0	0	21866	8336

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
0	0	530	182

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 Medicaidb" Didn't meet eligibility criteria anymoreb" Didn't complete documentationb" Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	0	4840	1655

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): to be completed next year

This year, please report data about your cohort for this section.

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
0	0	20323	7811

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
0	0	534	188

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 Medicaidb" Didn't meet eligibility criteria anymoreb" Didn't complete documentationb" Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	0	6379	2174

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?

Question 12,14,17 and 19 were intentionally left blank, as data is unavailable at this time.

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

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.

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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 2021?

318

7.

How many cases have been found in favor of the beneficiary in FFY 2021?

147

8.

How many cases related to provider credentialing were investigated in FFY 2021?

1

9.

How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2021?

0

10.

How many cases related to provider billing were investigated in FFY 2021?

1160

11.

How many cases were referred to appropriate law enforcement officials in FFY 2021?

68

12.

How many cases related to beneficiary eligibility were investigated in FFY 2021?

30

13.

How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2021?

11

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.

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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 2021?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
7051	23381	57812	87213	115392	92061

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 2021?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
323	7804	32868	54819	64898	41446

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 2021?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
294	7773	32522	54132	63720	40003

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 2021?

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
73	1005	11221	26087	27255	19138

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 2021?

13676

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. For the 2021 CARTS report, we highly encourage states to report all raw CAHPS data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database instead of reporting a summary of the data via CARTS. For 2022, the only option for reporting CAHPS results will be through the submission of raw data to ARHQ.

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).

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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 5.0H 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 November 2020 to February 2021. 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 to 2018, improvement has been seen across many measures including rating of specialist child saw most often, getting an appointment quickly with a specialist, and rating of all child's healthcare. b"The areas of opportunities for potential improvement include care coordination and access to care. Examples of coordination include the child's health plan, doctor's office, or clinic helping to coordinate services for children with chronic conditions. Examples of access include the ability to easily access emotional, developmental, or behavioral health treatment or counseling for your child.

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?

The 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?

121

5.

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

121

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. In addition, 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?

The Hunger Prevention and Nutrition Assistance Program (HPNAP) provides emergency food relief and nutrition services to food insecure populations in New York State. More than 300 million emergency meals are provided through a network of approximately 2,500 Emergency Food Relief Organizations (EFRO). Currently, HPNAP funding supports 45 contracts that include eight regional food banks and 37 Direct Service providers statewide.

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)

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1. What is the name of your HSI program?

Opioid Drug Addiction and Opioid Overdose Prevention Program 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?

The Opioid Overdose Prevention Program is Statewide in scope and serves individuals who are at risk of either experiencing an opioid overdose or of encountering one. Program funding is used to train individuals through the State as opioid overdose responders. The public health law was expanded in an amendment effective August 11, 2015 to specifically include school districts, boards of cooperative educational services, county vocational education and extension boards, charter schools and nonpublic elementary and/or secondary schools, as well as persons employed by these districts, boards or schools.

4.

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

329118

5.

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

149508

Computed: 45.43%

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 principal metric for measuring the impact of the HSI program is the number of school personnel who have been trained through the OOPP initiative. These trained individuals are positioned for saving lives pending the arrival of EMS. Time is of the essence in administering naloxone.

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

More than 34,000 school personnel have been trained in overdose recognition and response since 2015, with more than 2,500 having been trained in the first nine months of 2021.

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

New York State's Opioid Overdose Prevention Program (OOPP) initiative, which began in 2006 and which is managed by the NYS Department of Health in the AIDS Institute's Office of Drug User Health, trains non-medical persons through a network of registered programs to recognize opioid overdoses and to respond appropriately by calling 911 and administering the life-saving antidote, naloxone. The initiative currently has over 850 registered programs, which, in addition to training community members, provide naloxone to them at no cost. NYSDOH furnishes naloxone to the registered programs. Naloxone is the centerpiece in the State's commitment to combatting overdose mortality. In 2015, NYSDOH collaborated with the State Education Department to bring opioid overdose response capacity to the State's secondary school campuses. The initiative's registered programs today include 112 school districts representing 478 distinct schools. In addition to these school districts, many other registered programs, including local health departments, train school personnel. The importance of quick access to naloxone has been exacerbated by the presence of fentanyl, a synthetic opioid 100 times more powerful than heroin, in the illicit drug supply. Fentanyl is increasingly found in non-opioid drugs, including stimulants and pressed pills.

9.

Optional: Attach any additional documents.

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

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1. What is the name of your HSI program?

Coordinating Care and Supporting Transition for Children and Adolescents and Young Adults with Sickle Cell Disease

2.

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

○ Yes

○ No

3. Which populations does the HSI program serve?

The sickle cell screening program provides transition services for adolescents and young adults with sickle cell disease and other hemoglobinopathies. The goal of the program is to ensure that adolescents and young adults with sickle cell disease and other hemoglobinopathies are able to transition from pediatric health care and parent-directed control of their health to adult care and self-directed control of their health.

4.

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

525

5.

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

Computed:

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.

> Number of children at three Hemoglobinopathy Centers that kept their transition service appointments. Unable to report on question 5 as this data is only collected on an aggregate level.

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

> Number of transition readiness assessments completed among children that kept their appointments.

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

> The Coordinating Care and Supporting Transition for Children and Adolescents and Young Adults with Sickle Cell Disease program supports three Hemoglobinopathy Centers (HC) in New York State to assist adolescents and young adults successfully transition from pediatric to adult/self care. The program goal is to reduce morbidity and mortality in children/AYA with Sickle Cell Disease (SCD) during transition. Transition Navigators at HCs are funded by this program to assist patients with peer support, medication adherence, appointment reminders, disease education, family engagement, specialist referrals and self-management, and refer youth to be trained as youth ambassadors.

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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1. What is the name of your HSI program?

New York State and New York City Poison Control Hotlines

2.

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

◉ Yes

○ No

3. Which populations does the HSI program serve?

The poison control center located upstate serves the upstate area. The New York City Poison Control Center (NYCPCC's) designated calling region is the 5 boroughs of New York City, Nassau Suffolk and Westchester counties (8 counties in all).

4.

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

30351

5.

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

15176

Computed: 50%

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 zip codes where poison control centers focus their educational efforts are prioritized by low income and population density. Poison Control Centers also partner with community groups who are reaching these communities as well (Head Start, WIC, NY Children Services). The Poison Control Centers strive to make sure their hotline is staffed 24 hours a day, 7 days a week, everyday of the year.

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

Poison Control Centers have process outcomes that look at the number of events completed in targeted zip codes. When measuring the impact of their hotline, the Poison Control Center identified it was available every day to children across the State.

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

The New York State and New York City Poison control hotlines are emergency medical hotlines that take calls from both the public and health care providers regarding intentional and unintentional exposures (which can involve (but not limited to) medications, plants, household chemicals, gases and vapors such as carbon monoxide, drugs of abuse, bites and envenomation). These cases are triaged by Poison Control Center staff. Ideally, patients are kept at home to reduce the use of 911/EMS/ERs if not necessary. If the call is from a health care provider, the staff work as a team member in the treatment of the patient by advising the on site treating team what toxic effects can be seen, what antidotes are available and basic medical management to decrease unnecessary medical expenditure. The Centers' public educational programs are geared to raise awareness and build confidence in our communities with predominantly parent groups (Head Start and WIC) to encourage parents to reach out to poison control prior to calling 911. Since New York's community is so diverse, this brings many challenges with language being one. In addition, NYCPCC works extensively with New York Children's Services (ACS) who have a significant number of families living in homeless shelters.

9.

Optional: Attach any additional documents.

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1. What is the name of your HSI program?

The New York State Early Intervention Program (EIP)

2.

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

(•)   Yes

( )   No

3. Which populations does the HSI program serve?

| Infants and toddlers birth to age 3 found eligible for the EIP. |

4.

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

| 64840 |

5.

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

| |

Computed:

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.

While EIP does not track family income, approximately more than 50% of the families with children found eligible for EIP services are Medicaid eligible. Child outcome surveys are conducted annually and complied as part of the State's Annual Performance Report to the federal Department of Education to measure children's progress upon exiting the EIP. One metric the EIP program uses to measure the impact of this program on the health of low-income children in New York is the percent of children who substantially increased their rate of growth in social skills and behavior by the time they turned 3 years of age or exited the program.

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

The most recent report for the EIP program dated February 2021 indicated that over 70% of children substantially increased their rate of growth in social skills and behavior.

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

The New York State EIP is part of the national Early Intervention Program for infants and toddlers with disabilities and their families, under the Individuals with Disabilities Education Act (IDEA). The New York State Department of Health (DOH) is designated as the lead agency for the state and is responsible for general administration, supervision and oversight of the program that is administered by the 57 counties and NYC. The mission of the program is to identify and evaluate as early as possible those infants and toddlers whose healthy development is compromised and provide for appropriate intervention to improve the family and child's development. The program is family-centered and supports parents in meeting their responsibility to nurture and enhance their child's development. To be eligible for services, a child must be under three years of age and have a confirmed disability or established developmental delay. A disability means that a child has a diagnosed physical or mental condition that may lead to developmental problems.

9.

Optional: Attach any additional documents.

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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 in New York State in most current survey year.

4.

Numerator (total number)

2

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

Computed: 66.67%

7.

What is the date range of your data?

Start
mm/yyyy

01 / 2018

End
mm/yyyy

12 / 2020

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?

Limitations in the reporting template only allow for reporting of whole numbers this year. Progress towards goal is closer to 82% (2.48/3.01), not 66.67% as shown in the report using only whole numbers. It appears New York has made progress towards our goal when comparing to last year's data for this measure which was 93.69% (2.82/3.01). However, due to the limitations of this year's ACS data, the ACS data for 2020 should not be compared to ACS data for other years and limits inferences that can be made from this data set.

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. As mentioned in section 3A, 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.

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

The numerator used was from the experimental American Community Survey data table XK202701. Due to the limitations on the 2020 survey data, we were unable to stratify the data further to only capture those under 400% FPL. Due to the impacts of the COVID-19 PHE on collection of ACS data, the 2020 ACS utilized an experimental estimation methodology and should not be compared to any other ACS year.

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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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.

Increase Access to Care

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 210 days, and had at least two follow up visits with a practitioner 9 months after initiation phase.

4.

Numerator (total number)

2521

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)

3767

Computed: 66.92%

7.

What is the date range of your data?

Start

mm/yyyy

| 03 | / | 2019 |

End

mm/yyyy

| 02 | / | 2020 |

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?

Remained about the same.

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?

> The COVID-19 pandemic has impacted regular access to care including, preventive care for children and adolescents. Despite these challenges, the percentage of children accessing their prescription medication has stayed level, indicating that care continued to be provided to children and adolescents and met their clinical needs.

12.

Do you have any supporting documentation?

Optional

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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)

2906

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)

6091

Computed: 47.71%

7.

What is the date range of your data?

Start
mm/yyyy

01 / 2020

End
mm/yyyy

12 / 2020

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?

Improved, moved from 45.18% to 47.71%

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. A focus on childhood vaccinations has remained an important component of NYS Department of Health efforts. Despite impacts of COVID-19, the Department supported pediatricians and clinical practices at maintaining preventive visits.

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

No.

12.

Do you have any supporting documentation?

Optional

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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?

> There are no new plans currently for measuring and reporting on our goals and objectives. COVID-19 has not impacted our public reporting although we caution to some effect that some measures may be impacted by medical record review or the pandemic. Those measure are not included in our goals and objectives here.

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 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.

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Program Financing

Tell us how much you spent on your CHIP program in FFY 2021, and how much you anticipate spending in FFY 2022 and 2023.

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 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 772,447,354	$ 857,500,000	$ 910,000,000

2.

How much did you spend on Fee for Service in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 0	$ 0	$ 0

3.

How much did you spend on anything else related to benefit costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 885,581,125	$ 911,301,000	$ 911,600,000

4.

How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 66,101,000	$ 66,000,000	$ 66,000,000

Table 1: Benefits Costs

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

Type	FFY 2021	FFY 2022	FFY 2023
Managed Care	772447354	857500000	910000000
Fee for Service	0	0	0
Other benefit costs	885581125	911301000	911600000
Cost sharing payments from beneficiaries	66101000	66000000	66000000
Total benefit costs	1724129479	1834801000	1887600000

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 2021? How much do you anticipate spending in FFY 2022 and 2023?

This includes wages, salaries, and other employee costs.

2021	2022	2023
$ 0	$ 0	$ 0

2.

How much did you spend on general administration in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 25,749,811	$ 26,522,305	$ 27,317,974

3.

How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 0	$ 0	$ 0

4.

How much did you spend on claims processing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 0	$ 0	$ 0

5.

How much did you spend on outreach and marketing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 3,253,944	$ 3,351,562	$ 3,452,109

6.

How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 147,877,076	$ 159,326,243	$ 164,296,583

7.

How much did you spend on anything else related to administrative costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 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 2021	FFY 2022	FFY 2023
Personnel	0	0	0
General administration	25749811	26522305	27317974
Contractors and brokers	0	0	0
Claims processing	0	0	0
Outreach and marketing	3253944	3351562	3452109
Health Services Initiatives (HSI)	147877076	159326243	164296583
Other administrative costs	0	0	0
Total administrative costs	176880831	189200110	195066666
10% administrative cap	176880831	189200111.11	195066666.67

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 2023 will be calculated once the eFMAP rate for 2023 becomes available. In the meantime, these values will be blank.

FMAP Table	FFY 2021	FFY 2022	FFY 2023
Total program costs	1901010310	2024001110	2082666666
eFMAP	65	65	Not Available
Federal share	1235656701.5	1315600721.5	Not Available
State share	665353608.5	708400388.5	Not Available

8.

What were your state funding sources in FFY 2021?

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 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

2021	2022	2023
541800	568900	597300

2.

What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?

Round to the nearest whole number.

2021	2022	2023
$ 236	$ 238	$ 240

Type	FFY 2021	FFY 2022	FFY 2023
Eligible children	541800	568900	597300
PMPM cost	236	238	240

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 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

2021	2022	2023
0	0	0

2.

What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?

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.

2021	2022	2023
$ 0	$ 0	$ 0

Type	FFY 2021	FFY 2022	FFY 2023
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.

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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?

New York continues to prioritize children's health care coverage under the leadership of Governor Hochul. Governor Hochul has demonstrated her 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 2021?

> The greatest challenge New York's CHIP program has faced during FFY 2021 continues to be 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. New York State has been working diligently to develop plans to unwind the public health emergency with the goal of maintaining coverage for as many children as possible. While plans are begin developed, the uncertainty of the timing of the wind down makes this process challenging.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2021?

> The greatest accomplishment New York's CHIP program experienced in FFY 2021 was implementing 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. While the waiting period had already been removed in New York State statute, system changes were not made due to other priorities and children were removed from the waiting period manually. This change was made in July 2021.

4. What changes have you made to your CHIP program in FFY 2021 or plan to make in FFY 2022? Why have you decided to make these changes?

In FFY 2021, New York's CHIP program continued to implement temporary adjustments to programmatic rules to ensure that children remain enrolled during the COVID-19 public health emergency. Renewals continue to be extended as the public health emergency has been extended to ensure that children remain enrolled, additional time continues to be allowed for families to submit documentation in support of their application and children continue to 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 2022, New York State will be taking steps to operationalize the unwind of the public health emergency to ensure that the most children possible remain covered. This includes ensuring that contact information, including mailing addresses, are current, providing advance notice when enforcement of disenrollment for failure to pay family premium contributions and adjusting the reasonable compatibility threshold to allow for more children to be renewed administratively. The Child Health Plus program will also be included in statewide efforts to educate consumers on the unwind.

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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