

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The template includes the following sections:

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

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

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

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

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

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

Medicaid Expansion- CHIP SPA Requirements

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

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

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

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

Medicaid Expansion- Medicaid SPA Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Original Plan

Original Submission

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

SPA #1

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

SPA #2

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

SPA #3

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

SPA #4

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

SPA #5 (compliance)

Submission date: March 31, 2003

SPA #6 (renewal process)

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

SPA #7

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

SPA #8

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

SPA #9

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

SPA # 10

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

SPA # 11

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

SPA # 12

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

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

SPA #21	
Submission date:	March 31, 2015
Effective date:	April 1, 2014
Implementation date:	April 1, 2014
SPA #NY-16-0022- C-A	
Submission date:	March 28, 2016
Effective date: (HSI for Poison Control Centers and Sickle Cell Screening):	April 1, 2015
Effective date (Ostomy Supplies):	May 1, 2015
Implementation date:	April 1, 2015 and May 1, 2015
SPA #NY-16-0022- C – B	
Submission date:	March 28, 2016
Effective date (HSI Medical Indemnity Fund):	April 1, 2015
Implementation date:	April 1, 2015
SPA #NY-17-0023 – C - A	
Submission date:	March 31, 2017
Effective date (HSI Opioid Drug Addiction and Opioid Overdose Prevention Program for Schools, Hunger Prevention Nutrition Assistance Program (HPNAP)):	April 1, 2016
Effective date (Coverage for Newborns):	January 1, 2017
Implementation date:	April 1, 2016 and January 1, 2017
SPA #NY – 19-0024	
Submission date:	March 27, 2019
Effective date (Transition of Children to NY State of Health):	
Effective Date (Allowing Children to Recertify on the Last Day of the Month of their Enrollment Period):	
Implementation Date:	April 1, 2018
SPA #NY- 20-0026	
Submission Date:	March 18, 2020
Effective Date: Mental Health Parity Compliance	April 1, 2019
Implementation Date:	April 1, 2019

SPA #NY- 20-0027	
Submission Date:	March 31, 2020
Effective Date: Compliance with Managed Care Regulations	April 1, 2019
Implementation Date:	April 1, 2019
SPA #NY- 20-0028	
Submission Date:	March 31, 2020
Effective Date: Disaster Relief Provisions	March 1, 2020
Implementation Date:	March 1, 2020
SPA #NY- 20-0029	
Submission Date:	June 25, 2020
Effective Date: (HSI Early Intervention Program) Provisions	April 1, 2020
Implementation Date:	April 1, 2020
SPA #NY- 20-0029-A	
Submission Date:	June 25, 2020
Effective Date: (HSI Newborn Screening Program) Provisions	April 1, 2020
Implementation Date:	April 1, 2020
SPA #NY- 21-0030	
Submission Date:	March , 2021
Effective Date: Support Act Provisions	April 1, 2020
Implementation Date:	April 1, 2020

Superseding Pages of MAGI CHIP State Plan Material

State: New York

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
NY-14-0001 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low-Income Children	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3
		CS15	MAGI-Based Income Methodologies	Incorporate within a separate subsection under section 4.3
NY-14-0002 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
NY-14-0003 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
NY-13-0004 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
NY-14-0005 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17	Residency	Supersedes the current section 4.1.5
		CS18	Citizenship	Supersedes the current sections 4.1.0; 4.1.1-LR, 4.1.1-LR
		CS19	Social Security Number	Supersedes the current section 4.1.9.1
		CS20	Substitution of Coverage	Supersedes the current section 4.4.4
	General Eligibility	CS21	Substitution of Coverage	Supersedes the current section 8.7
		CS27	Non-Payment of Premiums	Supersedes the current section 4.1.8
	CS28	Continuous	Supersedes the current section 4.3.2	

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
			Eligibility Presumptive Eligibility for Children	
NY-19-0025 Effective/Implementation Date: April 1, 2018	Non-Financial Eligibility	CS20	Substitution of Coverage	Supersedes the previously approved CS20.

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

Consistent with New York’s approved tribal consultation policy, a letter was mailed to all federally recognized tribes in New York State on March 17, 2021 notifying them of the proposed State Plan Amendment. A link was provided in the letter for purposes of allowing the tribes to view the proposed State Plan Amendment. The tribes were given two weeks to provide comments/feedback on the proposed State Plan Amendment.

TN No: Approval Date Effective Date

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state’s CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

6.3.1- BH Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

The state requires MCOs to use age-appropriate education, testing and screening during well childcare visits in accordance with guidance from the American Academy of Pediatrics.

6.3.1.1- BH The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

6.3.1.2- BH The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

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

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

6.3.2.1- BH Psychosocial treatment
Provided for: Mental Health Substance Use Disorder

MCOs cover services with no limitations. Services must be provided by certified and/or licensed professionals. Visits may include family therapy if such therapy is

directly related to the enrolled child's mental health or substance use disorder treatment.

6.3.2.2- BH Tobacco cessation
Provided for: Substance Use Disorder

MCOs provide coverage for both nicotine replacement products and medications used to aid in smoking cessation, in accordance with FDA specifications for adolescents.

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

6.3.2.3- BH Medication Assisted Treatment
Provided for: Substance Use Disorder

6.3.2.3.1- BH Opioid Use Disorder

MCOs provide coverage for a supply of medication for emergency conditions and all types of medications used for management of opioid withdrawal and/or stabilization.

6.3.2.3.2- BH Alcohol Use Disorder

MCOs provide coverage for medications used for management of alcohol withdrawal and/or stabilization.

6.3.2.3.3- BH Other

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

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

6.3.2.6- BH Respite Care
Provided for: Mental Health Substance Use Disorder

6.3.2.7- BH Intensive in-home services
Provided for: Mental Health Substance Use Disorder

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

MCOs provide coverage of services without limitations. Intensive outpatient services must be provided by certified and/or licensed professionals.

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

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

6.3.3- BH Day Treatment
Provided for: Mental Health Substance Use Disorder

6.3.3.1- BH Partial Hospitalization
Provided for: Mental Health Substance Use Disorder

Partial hospitalization covered when medically necessary. No limitations for services to treat emergency condition in a facility operated by OMH.

6.3.4- BH Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))

Provided for: Mental Health Substance Use Disorder

No limitations for inpatient mental health and detoxification services. Services to be provided in a facility operated by OMH under sec. 7.17 of the Mental Hygiene Law, or a facility issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law or a general hospital as defined in Article 28 of the Public Health Law.

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which

the residential treatment services are provided).

6.3.4.1- BH Residential Treatment
Provided for: Mental Health Substance Use Disorder

6.3.4.2- BH Detoxification
Provided for: Substance Use Disorder

No limitations for inpatient detoxification. Services to be provided in a facility operated by OMH under sec. 7.17 of the Mental Hygiene Law, or a facility issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law or a general hospital as defined in Article 28 of the Public Health Law.

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility-based services in order to avoid inpatient hospitalization.

6.3.5- BH Emergency services
Provided for: Mental Health Substance Use Disorder

No limitations for treatment of emergency services in a hospital or facility operated by office of mental health for short-term acute diagnosis and treatment of mental health and substance use disorder conditions.

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

MCOs cover services for diagnosis, symptom alleviation and therapeutic stabilization of signs and symptoms. No limitations for services.

6.3.6- BH Continuing care services
Provided for: Mental Health Substance Use Disorder

MCOs provide coverage for continuing mental health and substance abuse services. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from the initial assessment and subsequent item assessment over duration of intervention in objective and measurable terms.

6.3.7- BH Care Coordination
Provided for: Mental Health Substance Use Disorder

MCO Case Managers provide care coordination with no limitations, as medically necessary, to ensure needs and preferences for health services and information sharing are met.

6.3.7.1- BH Intensive wraparound
Provided for: Mental Health Substance Use Disorder

6.3.7.2- BH Care transition services
Provided for: Mental Health Substance Use Disorder

6.3.8- BH Case Management
Provided for: Mental Health Substance Use Disorder

MCO Case Managers provide developmentally appropriate services with no limitations as medically necessary to support overall health and wellness. Case Management services includes linkage to services for the parents and caregivers as needed.

6.3.9- BH Other
Provided for: Mental Health Substance Use Disorder

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

ASAM Criteria (American Society Addiction Medicine)
 Mental Health Substance Use Disorders

InterQual
 Mental Health Substance Use Disorders

MCG Care Guidelines
 Mental Health Substance Use Disorders

CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
 Mental Health Substance Use Disorders

CASII (Child and Adolescent Service Intensity Instrument)
 Mental Health Substance Use Disorders

CANS (Child and Adolescent Needs and Strengths)
 Mental Health Substance Use Disorders

- State-specific criteria (e.g. state law or policies) (please describe)
 Mental Health Substance Use Disorders

NYS Office of Addiction Services and Supports (OASAS) Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) tool. This is an evidenced based, peer reviewed web-based tool that evaluates patient risks and resources, to assist treatment providers in determining appropriate levels of care for clients.

- Plan-specific criteria (please describe)
 Mental Health Substance Use Disorders

- Other (please describe)
 Mental Health Substance Use Disorders

- No specific criteria or tools are required
 Mental Health Substance Use Disorders

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

6.4.2- BH Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

MCOs, through their contracts with participating providers, include guidelines such as the specific tested evidence-based tools that should be used in determining treatment plans. MCOs provide updates and guidance to their participating providers as needed.

6.2.5- BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

The state will provide all behavioral health benefits consistent with 42 CFR 457.495

to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.