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:
Gabrielle Armenia	CHIP Director Director, Division of Eligibility and Marketplace Integration Office of Health Insurance Programs

Disclosure Statement This information is being collected 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)
- Added new assurances related to the coverage of vaccines (Sections 2103(c)(1)(D) and (c)(12));

(Section 11405(b)(1) of the Inflation Reduction Act (IRA)); (SHO # 23-003, issued June 27, 2023)

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-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 -19-0025

Submission date:	March 28, 2019
Removal of the 90 day Waiting Period.	
Effective Date:	April 1, 2018
Implementation Date:	April 1, 2018

SPA #NY- 20-0026– *Pending Approval*

Submission Date:	March 18, 2020
Effective Date Mental Health Parity Compliance:	April 1, 2019
Implementation Date:	April 1, 2019

SPA #NY- 20-0027– *Pending Approval*

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- 21-0030 – *Pending Approval*

Submission Date:	March 31, 2021
Effective Date: Support Act Provisions	April 1, 2020
Implementation Date:	April 1, 2020

SPA #NY- 21-0031-CHIP

Submission Date:	March 31, 2022
Effective Date: Ends Manual Process to Remove Children from the Child Health Plus Waiting period and replaces CS 20 attachment:	July 15, 2021
Implementation Date:	July 15, 2021

SPA #NY- 21-0032-CHIP

Submission Date:	March 31, 2022
Effective Date: Compliance with the American Rescue Plan Act of 2021:	March 11, 2021
Implementation Date:	March 11, 2021

SPA #NY-22-0033-CHIP

Submission Date:	September 15, 2022
Effective Date: Elimination of the $9 Family Premium Contribution:	October 1, 2022
Implementation Date:	October 1, 2022

SPA #NY-23-0034-CHIP

Submission Date: From conception to the end of pregnancy (FCEP)	March 7, 2023
Effective Date: Coverage:	April 1, 2022
Implementation Date:	April 1, 2022

SPA #NY-23-0034A-CHIP

Submission Date: From conception to the end of pregnancy (FCEP) Option (MMDL CS9)	March 7, 2023
Effective Date: Coverage:	April 1, 2022
Implementation Date:	April 1, 2022

SPA #NY-23-0035-CHIP - *Pending Approval*

Submission Date:	March 21, 2023
Effective Date: Expansion of Child Health Plus Covered Health Services in Accordance with Public Health Law §2510(7):	January 1, 2023
Implementation Date:	January 1, 2023

SPA #NY-24-0036-CHIP

Submission Date:	February 23, 2023
Effective Date: 2-Month Postpartum Continuous Eligibility in CHIP	March 1, 2023
Implementation Date:	March 1, 2023

SPA #NY-24-0037-CHIP

Submission Date: March 26, 2024
Benefit Expansion: Residential Rehabilitation for Youth
Effective Date: April 1, 2023
Implementation Date: April 1, 2023

SPA #NY-24-0038-CHIP

Submission Date: March 29, 2024
End of Year Compliance SPA
Effective Date: April 1, 2023
Implementation Date: April 1, 2023

SPA #NY-24-0039-CHIP

Submission Date: March 29, 2024
Demonstrate Compliance with the Inflation Reduction Act (IRA) requirement for Coverage of Age-Appropriate Vaccines and Their Administration, Without Cost Sharing
Effective Date: October 1, 2023
Implementation Date: October 1, 2023

SPA #NY-24-0040-CHIP

Submission Date: March 29, 2024
Demonstrate Compliance with statutory amendments made by Section 5112 of the Consolidated Appropriations Act, 2023
12-months Continuous Eligibility
Effective Date: January 1, 2024
Implementation Date: January 1, 2024

SPA #NY-25-0041-CHIP - *Pending Approval*

Submission Date: March X, 2025
HSI 12-month Post Partum
Effective Date: April 1, 2024
Implementation Date: April 1, 2024

SPA #NY-25-0042-CHIP - *Pending Approval*

Submission Date: March , X 2025
Implementation of
Home and Community Based Services
Effective Date: January 1, 2025
Implementation Date: January 1, 2025

SPA #NY-25-0043-CHIP

Submission Date: March X, 2025
End of Year Compliance
SPA (0-6 Continuous Enrollment and
Demonstrates Compliance
with statutory amendments
made by Section 5121 of the
Consolidated Appropriations Act, 2023)
Effective Date: January 1, 2025
Implementation Date: January 1, 2025

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

		CS28	Presumptive Eligibility for Children	Supersedes 4.3.2
NY-19-0025 Effective/Implementation Date: April 1, 2018	Non-Financial Eligibility	CS20	Substitution of Coverage	Supersedes the previously approved CS20.
NY-23-0034A-CHIP Effective/Implementation Date: April 1, 2022	Eligibility	CS9	Coverage From Conception to Birth	
NY-24-0040-CHIP Effective/Implementation Date: January 1, 2024	General Eligibility	CS27	Continuous Eligibility	Supersedes Section 4.1.7, 4.1.8, 4.1.9
	Non-Financial Eligibility	CS 21	Non-Payment of Premiums	Supersedes Section 8.7, 8.7.1.1, 8.7.1.2

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

Section 4. Eligibility Standards and Methodology

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

4.1.7 ☒ Access to or coverage under other health coverage:

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

Effective April 1, 2022, New York provides coverage from conception to the end of pregnancy (FCEP) for uninsured pregnant consumers with income up to and including 218% FPL, plus 5% deduction, not otherwise eligible for Medicaid or CHIP. In determining household size, the "unborn child" or "children" will be counted as if born and living with the pregnant parent.

Effective January 1, 2024, families who report or are found to have other health insurance coverage, public minimum essential coverage, except Medicaid, or children who gain access or enrollment into a state health benefits plan, the New York State Health Insurance Program (NYSHIP), during the course of their 12-month enrollment period, will remain enrolled in the Child Health Plus program for the remainder of their 12-month continuous eligibility period and will become ineligible for Child Health Plus at renewal.

In accordance with the November 14, 2024 approval of New York's section 1115 waiver demonstration amendment, effective January 1, 2025, children from birth up to age six whose families report or who are found to have other health insurance coverage, public minimum essential coverage, except Medicaid, or who gain access or enrollment into a state health benefits plan, the New York State Health Insurance Program (NYSHIP), will remain enrolled in the Child Health Plus program until the end of the month in which their sixth birthday falls. These children will become ineligible for Child Health Plus following the end of the month in which their sixth birthday falls if they are still found to have other health insurance coverage, public minimum essential coverage, except Medicaid, or if they gain access or enrollment into a state health benefits plan, the New York State Health Insurance Program (NYSHIP).

4.1.8 ☒ Duration of eligibility, not to exceed 12 months:

The period of eligibility shall commence on the first day of the month during which a child is determined eligible, as described below, an end on the last day of the twelfth month of coverage. The period of eligibility shall cease if the child no longer resides in New York State; has become eligible for Medicaid; has reached the age of 19; the child or child's representative requests a voluntary termination of eligibility; the state determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of state error or fraud, abuse, or perjury attributed to the child of the child's representative; or the child dies.

At the State's discretion, either allow additional time for enrollees to pay outstanding family premium contributions or waive such contributions for enrollees living in and/or working in FEMA or Governor declared disaster areas at the time of the disaster event. In the event of a disaster, the State will notify CMS of the intent to provide temporary adjustments to its enrollment and/or re-determination policies, the effective dates of such adjustments and the counties/areas impacted by the disaster.

Effective January 1, 2014, children whose application is submitted to NY State of Health, New York's Health Insurance Marketplace, by the 15th of the month, shall be enrolled on the first day of the next month if determined eligible. Applications received by NY State of Health after the 15th day of the month will be processed for the first day of the second subsequent month. In no case is a child enrolled more than 45 days after submission of the application. Implemented on October 2017, if a child renews their coverage after the 15th day of the month but before the last day of the month of their 12-month enrollment period and the child selects the same health plan, the child will remain continuously enrolled effective the first day of the subsequent month.

Effective June 1, 2023, if a child renews their coverage in the month following their prior 12-month enrollment period, and the child selects the same health plan, the child will be given retroactive coverage to the first day of the month, following their prior 12-month enrollment period so the child will not experience a gap.

Effective January 1, 2017, a newborn who applies for coverage, is found eligible for the Child Health Plus program and selects a health plan within 60 days of the child's date of birth, will be given eligibility retroactive to the first day of the month of the child's date of birth. The family is provided with the option to choose the enrollment start date which can be either retroactive to the first of the month of the date of birth, the first of the month after the date of birth or prospective based on the 15th day of the month rule described above.

Implemented on August 1, 2017, children who originally enrolled directly with a health plan prior to January 1, 2014 will be transitioned to NY State of Health, New York's Health Insurance Marketplace, at their annual renewal. Children will receive a notice approximately 60 days prior to their renewal

with instructions regarding how they must renewal their coverage in NY State of Health If the child appears Medicaid eligible at renewal, the child will be enrolled in Medicaid through NY State of Health. The process to transition children originally enrolled with a health plan to NY State of Health was completed on July 31, 2018.

Families are required to report changes in New York State residency or health insurance coverage that would make a child ineligible for subsidy payments. Effective January 1, 2014, these changes must be provided to NY State of Health if that is where enrollment originated. If enrollment originated with the health plan prior to January 1, 2014 and the child's enrollment was not yet transitioned to NY State of Health, changes must be reported directly to the health plan. If a family submits required eligibility information that affects their enrollment status, the information will be implemented prospectively. A family may incur a different family premium contribution or enrolled in Medicaid based on the new information.

Effective August 1, 2018 all changes are reported to NY State of Health as the transition of CHPlus children to NY State of Health was completed by 7/31/2018. If a family submits required eligibility information that affects their enrollment status, the information will be implemented prospectively. A family may incur a different family premium contribution or be enrolled in Medicaid based on the new information.

Effective January 1, 2024, families who report or are found to have other health insurance coverage, public minimum essential coverage, except Medicaid, or children who gain access or enrollment into a state health benefits plan, the New York State Health Insurance Program (NYSHIP), or become incarcerated during

the course of their 12-month enrollment period, will remain enrolled in the Child Health Plus program for the remainder of their 12-month continuous eligibility period and will become ineligible for Child Health Plus at renewal. Children who fail to pay the monthly family premium contribution during the course of their 12-month enrollment period will remain enrolled in the Child Health Plus program for the remainder of their 12-month continuous eligibility period. At the child's renewal, the family will be required to pay the family premium contribution for the initial month of the new 12-month enrollment period. If the payment is not made at that time, the new 12-month enrollment coverage period will be cancelled.

In accordance with the November 14, 2024 approval of New York's section 1115 waiver demonstration amendment, effective January 1, 2025, children from birth up to age six whose families report or who are found to have other health insurance coverage, public minimum essential coverage, except Medicaid, or who gain access or enrollment into a state health benefits plan, the New York State Health Insurance Program (NYSHIP), will remain enrolled in the Child Health Plus program until the end of the month in which their sixth birthday falls.

Children from birth up to age six will remain enrolled regardless of any change in the child's household income until the end of the month in which their sixth birthday falls.

Children from birth up to age six who fail to pay the monthly family premium contribution will remain enrolled in the Child Health Plus program until the end of the month in which their sixth birthday falls.

Children from birth up to age six will become ineligible for Child Health Plus following the end of the month in which their sixth birthday falls if they are found to have other health insurance coverage, public minimum essential coverage, except Medicaid, or if they gain access or enrollment into a state health benefits plan, the New York State Health Insurance Program (NYSHIP).

Children from birth up to age six who remain eligible for Child Health Plus but who have failed to pay the monthly family premium contribution during their continuous eligibility period until the end of the month in which their sixth birthday falls will be required to pay the family premium contribution at the child's renewal for the initial month of the new 12-month enrollment period which begins following the month in which their sixth birthday falls. If the payment is not made at that time, the new 12-month enrollment coverage period will be cancelled.

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

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

The state's treatment of inmates of a public institution complies with sections 2102(d) and 2110(b)(7) of the Act as follows:

The state does not terminate eligibility for children enrolled in a separate CHIP because the child is an inmate of a public institution unless the experience another permissible exception to CE in accordance with Section 2110 (b)(2)(A). The state does not elect to suspend CHIP coverage for the duration of a child's incarceration.

The state will process any application submitted by or on behalf of a child and make an eligibility determination for child health assistance to provide all services available under the CHIP state plan upon their release from the institution. Children applying for coverage who are within 30 days prior to their release and are found eligible for CHIP are provided services that are otherwise available under the CHIP state plan.

The state elects to provide all CHIP state plan benefits to eligible children who are inmates pending disposition of charges.

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

4.1.9.2 ☒ Continuous eligibility

Fully eligible children are granted twelve months of continuous eligibility with the following exceptions: the child no longer resides in New York State; the child has enrolled in Medicaid; the child has reached the age of 19; the child or child's representative requests a voluntary termination of eligibility; the state determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of state error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child dies.

In accordance with the November 14, 2024 approval of New York's section 1115 waiver demonstration amendment , effective January 1, 2025, fully eligible children from birth up to age six are granted continuous eligibility until the end of the month in which their sixth birthday falls with the following exceptions: the child no longer resides in New York State; the child has become eligible for Medicaid; the child or child's representative requests a voluntary termination of eligibility; the state determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of state error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child dies.

At the State's discretion, either allow additional time for enrollees to pay outstanding family premium contributions or waive such contributions for enrollees living in and/or working in FEMA or Governor declared disaster areas at the time of the disaster event. In the event of a disaster, the State will notify CMS of the intent to provide temporary adjustments to its enrollment and/or re- determination policies, the effective dates of such adjustments and the counties/areas impacted by the disaster.

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

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

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

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

FQHCs are required to bill MCOs for all encounters for which a supplemental payment is being requested. MCOs will make payments on those claims based on their current contract or approve those claims in cases where a capitated arrangement

exists between both parties. This information must be maintained and reported to the Department to ensure that the State is only making payment for an approved service that was properly billed. Based on the information reported to the Department from the FQHC, the Department will calculate the supplemental payment that is due to each FQHC for each MCO. This "supplemental payment" is the aggregate difference between what that FQHC is paid through contracts with MCOs and its specific Medicaid PPS rate accumulated for each month.

The total supplemental payments due to FQHCs will be added to the appropriate MCO's monthly voucher for their CHPlus enrollees. The MCO will pay the FQHC the supplemental payment no later than the end of the month they receive payment on their voucher. The Department will compare information received from the FQHCs to the encounter data submitted by the MCOs, reconcile any material differences and adjust the supplemental payments accordingly.

The Department incentivizes high quality primary care in the CHPlus program through the development and maintenance of patient-centered medical homes. The medical home initiative is based upon the standards developed by the National Committee for Quality Assurance's (NCQA) NYS Patient-Centered Medical Home Program (NYS PCMH). Additionally, a subset of providers classified as medical homes came together to establish the Adirondack Medical Home Multipayer Demonstration Program. This Program was established to improve health care outcomes and efficiency through patient continuity and coordination of services.

NYS PCMH is a model of care that seeks to strengthen the physician-patient relationship by promoting improved access, coordinated care, and enhanced patient/family engagement. Office-based primary care practitioners (physicians and registered nurse practitioners) and Article 28 clinics that are approved as a medical homes and recognized by the NCQA as meeting the requirements of the NYS PCMH program, will receive a per member payment for CHPlus enrollees assigned to them. Additionally, beginning April 1, 2024, all NYS PCMH-recognized Primary Care Providers who have a community referral system in place will receive an additional payment.

8.2.1. ☒ Premiums:

≤222% FPL $0 $0
>222%-250%* $15 $45
>250%-300% $30 $90
>300%-350%* $45 $135
>350%-400% $60 $180

*American Indians/Native Americans exempt from Family contribution At the State's discretion, non-payment of premiums may be temporarily forgiven/waived or families may be given additional time to pay their premiums for CHIP applicants and/or existing beneficiaries who reside and/or work in a State or federally declared disaster area. Effective January 1, 2024, children within their 12-month continuous eligibility period will not be terminated for non-payment of the monthly family premium contribution.

In accordance with the November 14, 2024 approval of New York's section 1115 waiver demonstration amendment effective January 1, 2025, children from birth to age six will remain enrolled regardless of any change in the child's household income and will not be terminated for non-payment of the monthly family premium contribution through the end of the month in which their sixth birthday falls.

* No cost-sharing imposed on the FCEP population.

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

If a subsidized enrollee has a family premium contribution, the initial premium contribution is due by the 10th of the month of the enrollment start date for coverage to be effectuated. If the family premium contribution is not received, the enrollee is cancelled for non-payment and must reapply for coverage through NY State of Health. The health plan will absorb the family premium contribution if it is not paid within the CE period. The state will reimburse the health plan the cost of coverage minus the family premium contribution. If payment for the initial month of the next CE period is received on or before the 10th of the month of the enrollment start date, the child will be enrolled in coverage and considered to be in their next CE period, regardless of any outstanding premiums from the prior CE period. For subsequent months of coverage, enrollees are billed monthly, either 60 or 90 days in advance prior to their month of coverage. The family premium contribution is due 30 days in advance of the month of coverage..

Effective January 1, 2024 fully eligible subsidized enrollees who are within their 12-month continuous eligibility (CE) period and do not pay the monthly family premium contribution will remain enrolled in coverage and will not be terminated for non-payment through the end of their 12-month CE.

In accordance with the November 14, 2024 approval of New York's section 1115 waiver demonstration amendment, effective January 1, 2025, fully eligible subsidized enrollees from birth through age six who do not pay the monthly family premium contribution will remain enrolled in coverage and will not be terminated for non-payment through the end of the month in which their sixth birthday falls.

Children from birth up to age six who remain eligible for Child Health Plus but who have failed to pay the monthly family premium contribution during their continuous eligibility period until the end of the month in which their sixth birthday falls will be required to pay applicable family premium contribution at the child's renewal for the initial month of the new 12-month enrollment period which begins following the month in which their sixth birthday falls. If the payment is not made at that time, the new 12-month enrollment coverage period will be cancelled.

Enrollees have the opportunity to update their income in NY State of Health and to provide proof of a decrease in income. If proof is required by NY State of Health, that would make the child eligible for Medicaid or for a lower family contribution NY State of Health would redetermine program eligibility and the family contribution based on the updated information.
At State discretion, families may temporarily be given additional time to pay their premiums or non-payment of premium may be temporarily forgiven/waived for existing CHIP beneficiaries who reside and/or work in a FEMA or Governor-declared disaster area.

There are no other charges associated with the program, and the family has the option of paying more than one month's family contribution at a time.

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

8.7.1.1. ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

Effective January 1, 2024, fully eligible subsidized enrollees who are within their 12-month continuous eligibility (CE) period and do not pay the monthly family premium contribution will remain enrolled in coverage and will not be terminated for non-payment through the end of their 12-month CE period.

In accordance with the November 14, 2024 approval of New York's section 1115 waiver demonstration amendment, effective January 1, 2025, fully eligible subsidized enrollees from birth through age six who do not pay the monthly family premium contribution will remain enrolled in coverage and will not be terminated for non-payment through the end of the month in which their sixth birthday falls.

Children from birth up to age six who remain eligible for Child Health Plus but who have failed to pay the monthly family premium contribution during their continuous eligibility period until the end of the month in which their sixth birthday falls will be required to pay applicable family premium contribution at the child's renewal for the initial month of the new 12-month enrollment period which begins following the month in which their sixth birthday falls. If the payment is not made at that time, the new 12-month enrollment coverage period will be cancelled.

8.7.1.2. ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

At the State's discretion, either allow additional time for enrollees to pay outstanding family premium contributions or waive such contributions for enrollees living in/and or working in FEMA or Governor declared disaster areas at the time of the disaster event. In the event of a disaster, the State will notify CMS of the intent to provide temporary adjustments to its enrollment and/or redetermination policies, the effective dates of such adjustments and the counties/areas impacted by the disaster.

Effective January 1, 2024, fully eligible subsidized enrollees who are within their 12-month continuous eligibility (CE) period and do not pay the monthly family premium contribution will remain enrolled in coverage and will not be terminated for non-payment through the end of their 12-month CE period.

In accordance with the November 14, 2024 approval of New York's section 1115 waiver demonstration amendment, effective January 1, 2025 fully eligible subsidized enrollees from birth through age six who do not pay the monthly family premium contribution will remain enrolled in coverage and will not be terminated for non-payment through the end of the month in which their sixth birthday falls.

Children from birth up to age six who remain eligible for Child Health Plus but who have failed to pay the monthly family premium contribution during their continuous eligibility period until the end of the month in which their sixth

birthday falls will be required to pay applicable family premium contributions at the child's renewal for the initial month of the new 12-month enrollment period which begins following the month in which their sixth birthday falls. If the payment is not made at that time, the new 12-month enrollment coverage period will be cancelled.

Section 9. Strategic Objectives and Performance Goals and Plan Administration

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
  - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
  - Total 1-year cost of adding prenatal coverage
  - Estimate of unborn children covered in year 1

STATE: NY	FFY Budget	FFY Budget	FFY Budget
Federal Fiscal Year	**2023-2024**	**2024-2025**	**2025-2026**
State's enhanced FMAP rate	**65%**	**65%**	**65%**
Benefit Costs			
Insurance payments			
Managed Care	$ 2,034,739,358	$ 2,136,714,972	$ 2,250,203,679
per member/per month rate	$ 179	$ 187	$ 195
Fee for Service			
Total Benefit Costs	**$ 2,034,739,358**	**$ 2,136,714,972**	**$ 2,250,203,679**
(Offsetting beneficiary cost sharing payments)	$ (49,502,745)	$ (50,000,000)	$ (50,000,000)
Net Benefit Costs	**$ 1,985,236,613**	**$ 2,103,299,790**	**$ 2,221,678,082**
Cost of Proposed SPA Changes - HCBS Benefit	**$ -**	**$ 2,218,757**	**$ 2,958,342**
Cost of Proposed SPA Changes - PCMH Enhancement	**$ -**	**$ 10,991,061**	**$ 10,991,061**
Cost of Proposed SPA Changes - 0-6 Continuous Coverage	**$ -**	**$ 3,375,000**	**$ 7,525,000**
Administration Costs			
Personnel	$ 2,425,281	$ 2,498,039	$ 2,572,981
General Administration	$ 35,833,981	$ 31,260,013	$ 31,168,813
Contractors/Brokers			
Claims Processing			
Outreach/Marketing	$ 1,325,089	$ 1,600,000	$ 1,600,000
Health Service Initiatives (Early Intervention)	$ 64,720,096	$ 64,720,096	$ 64,720,096
Health Service Initiatives (HPNAP)	$ 6,709,950	$ 6,709,950	$ 6,709,950
Health Service Initiatives (Poison Control)	$ 700,297	$ 700,297	$ 700,297
Health Service Initiatives (Opioid)	$ 100,000	$ 100,000	$ 100,000
Health Service Initiatives (Sickle Cell)	$ 100,000	$ 100,000	$ 100,000
Health Service Initiatives (Postpartum)	$ 51,962,047	$ 103,924,094	$ 103,924,094
Health Service Initiatives (Total)	$ 124,292,390	$ 176,254,437	$ 176,254,437
Other	$ 526,163	$ 541,948	$ 558,206
Total Administration Costs	**$ 164,402,905**	**$ 212,154,437**	**$ 212,154,437**
10% Administrative Cap	$ 220,581,846	$ 233,699,977	$ 246,853,120
Cost of Proposed SPA Changes (postpartum)	**$ 51,962,047**	**$ 120,508,912**	**$ 125,398,497**
Federal Share	$ 1,397,265,686.56	$ 1,505,045,247.48	$ 1,581,991,137.53
State Share	$ 752,373,831.22	$ 810,408,979.41	$ 851,841,381.75
Total Costs of Approved CHPlus Plan	**$ 2,149,639,518**	**$ 2,315,454,227**	**$ 2,433,832,519**