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: March 9, 2023
Effective Date: 12-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 25, 2025
Health Service Initiative (HSI)
for 12-month Postpartum Period
Effective Date: April 1, 2024
Implementation Date: April 1, 2024

SPA # NY-25-0042-CHIP

Submission Date: March 25, 2025
Implementation of Home and
Community Based Services
(HCBS) in Accordance with
Public Health Law §2510(7)
Effective Date: January 1, 2025
Implementation Date: January 1, 2025

SPA # NY-25-0043-CHIP- *Pending Approval*

Submission Date: March 31, 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

SPA # NY-26-0044-CHIP

Submission Date: March XX, 2026
End of Year Compliance
SPA
Effective Date: April 1, 2025
Implementation Date: April 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 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and

ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified , by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. **Health Services Initiatives-** Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

New York proposes to cover the following programs under the Health Services Initiatives provision:

1. Early Intervention Program

Program Details

Description

The New York State Early Intervention Program ("program") is part of the national Early Intervention Program for infants and toddlers with disabilities and their families. It was created by Congress in 1986 under the Individuals with Disabilities Education Act (IDEA). In New York, the program was established in Article 25 of the Public Health Law and has been in effect since July 1, 1993.

The New York State Department of Health ("Department") is designated as the lead agency for the state and is responsible for general administration, supervision and oversight of the program. The program is managed within the Department by the Bureau of Early Intervention.

The mission of the program is to identify and evaluate as early as possible those infants and toddlers whose healthy development is compromised and provide for appropriate intervention to improve the family and child's development. The program is family-centered and supports parents in meeting their responsibility to nurture and enhance their child's development. The program serves approximately 70,000 children. The

Department enters into agreements with providers who deliver the program's services. There are about 1,300 providers under agreement, with approximately 18,000 qualified personnel rendering services to children and their families.

Eligibility

To be eligible for services, a child must be under three years of age and have a confirmed disability or established developmental delay. A disability means that a child has a diagnosed physical or mental condition that may lead to developmental problems. These include, but are not limited to, autism, Down syndrome, motor disorders, or vision and hearing problems. A developmental delay signifies that a child is behind in some area of development, such as growth, learning and thinking, or communicating.

Services

The program offers a variety of therapeutic and support services to eligible infants and toddlers with disabilities and their families, including: family education and counseling; home visits; parent support groups; special instruction; speech pathology and audiology; occupational therapy; physical therapy; psychological services; service coordination; nursing services; nutrition services; social work services; vision services; and assistive technology devices and services. These services help the family learn the best ways to care for the infant/toddler, support and promote the child's development, and include the child in family and community activities.

The program is community-based. It creates opportunities for full participation of children with disabilities and their families in their communities by ensuring services are delivered in natural environments to the maximum extent appropriate. The services are provided anywhere in the community where the child typically spends their day, including the home; the child-care center or family day care home; community/recreational centers, play groups, playgrounds, libraries, or any place parents and young children go for fun and support; and early childhood programs and centers, such as Early Head Start.

The most recent report for the EIP program dated February 2025 indicated that over 76% of children substantially increased their rate of growth in social skills and behavior.

Process

The program is administered locally by 57 counties and New York City. Each locality has an Intervention Official and a designated office responsible for administration and oversight of the program. Referral to the local office is the first step of the process. Parents may refer their own child if they have a concern about their child's development. In New York, certain professionals are also required to refer children to the program if a developmental problem is suspected.
After referral, the infant/toddler is evaluated by qualified professionals. If the child is eligible, the local program assists the parents in obtaining services. A specially designed written plan is developed for each child in the program. The plan outlines and explains the services the child and family will receive. An ongoing service coordinator is assigned to each case and facilitates and monitors the process. A transition plan is developed for the child as they approach their third birthday.

Budget Details

Funding Sources and Payment Details for Services

The program's services are provided at no cost to the parents. Services are financed through a combination of state funding, local funding and third-party payers (commercial insurance and Medicaid). Pursuant to state Public Health Law, billing providers must seek payment in the first instance from third-party payers to the extent that a child has private insurance regulated by the state or is enrolled in Medicaid. While services are funded from multiple sources, only the state funding will be considered for this health services initiative.

Providers submit claims for services rendered via the New York Early Intervention System (NYEIS) or through a secure portal supported by the program's state fiscal agent (SFA), the Public Consulting Group. The SFA submits the provider claims to applicable third-party payers and generates standardized municipal voucher for the services that are not covered by third-party payers. The local offices make payment for costs not covered by the third-party payers. The state reimburses the local offices a portion of their costs through voucher payments in SFS.

Department and Local Office Administration

State funding supports contracts with the local offices for payment of local administration of the program. In addition, federal Department of Education funding contributes to local administration and the Department's administration of the program. However, no administration payments will be considered for this Health Services Initiative.

Disbursements

Total program disbursements are projected at approximately $165.0 million per year. Historically, payments to local offices for reimbursement of program services have accounted for approximately 98 percent of total program spending. The remaining 2 percent has funded contracts with the local offices for their administration of the program. The administration payments are excluded from this Health Services Initiative.

Appropriation

The program's state funding appropriation is located on page 747 in New York State's SFY 2020- 21 Enacted Budget for State Operations. The appropriation totals $165.0 million. The appropriation is in Center for Community Health Program major program within the Department's section of the budget bill. The funding source is the General Fund, Local Assistance account. The General Fund is the state's main operating fund.

General Ledger Journal Entries

With approval of this state plan amendment, general ledger journal entries will be processed in SFS to transfer eligible state funding Early Intervention Program disbursements to CHIP federal funding. The Bureau of Budget Management (BBM) within the Department will initiate the general ledger journal entries in SFS. These transactions require a second level of approval within the Department and approval by the Office of the New York State Comptroller. BBM will attach appropriate backup documentation to the

transactions. There are distinct program codes for the Early Intervention Program and CHIP, and there is a unique sub-program code within CHIP dedicated to health services initiatives. There are sub-program codes within Early Intervention to distinguish between services and administration expenditures. The applicable CHIP federal match rate for the quarter in which the original Early Intervention Program disbursement occurred will be used for the general ledger journal entries and for the claiming of these expenditures in the CMS-21 report.

Percentage Related to Children

As program eligibility is limited to individuals under age three, the entire population served is children under 18. Therefore, all Early Intervention disbursements will be considered related to children under 18. Total state funding program disbursements for a given period will be multiplied by the applicable CHIP federal matching rate to determine the amount eligible to be transferred to CHIP federal funding.

ASSURANCES

New York assures that the Early Intervention Program health services initiative described above will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds.

New York also assures the all (100 percent) of the funds transferred (state and federal) are retained by the Early Intervention Program.

2. Opioid Drug Addiction and Opioid Overdose Prevention Program for Schools
Program Details

Although there have been many successes in New York's community opioid overdose programs, deaths from overdose continue to climb. In 2013 there were 637 fatalities involving heroin throughout the State, or more than 12 deaths per week. Many overdoses occur with young people.

Since April 2006, New York State has had a program regulated by the Department of Health (the Department) through which eligible, registered entities provide training to individuals in the community on how to recognize an overdose and how to respond to it appropriately. The applicable law is Public Health Law Section 3309, and the regulations are found at Part 80 (80.138) of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York. These programs are administered within the Department by the Aids Institute.

The appropriate responses to an opioid overdose include calling 911 and administering naloxone (Narcan), an opioid antagonist which reverses the potentially life-threatening consequences of an overdose. Eligible entities include individual prescribers (physicians, physician assistants and nurse practitioners), drug treatment programs, health care facilities, local health departments (LDHs) and community-based organizations that have the services of clinical director.

Program funding is used to train individuals throughout the State as opioid overdose responders. The public health law was expanded in an amendment effective August 11, 2015 to specifically include school districts,

boards of cooperative educational services, county vocational education and extension boards, charter schools and nonpublic elementary and/or secondary schools, as well as persons employed by these districts, boards or schools. As such, they are expressly authorized to respond to opioid overdoses through the administration of naloxone. Over 265 programs have registered with the Department, and approximately 100,000 overdose responders have been trained to date.

The opioid program provides education to school staff on how to be a responder using the kits. The school districts either register with the Department as opioid overdose prevention programs or they work with other eligible organizations that have chosen to register. Although elementary schools are included in the statutory language, the focus has been on middle and high schools. There is a curriculum and a mechanism for school staff to be trained in opioid overdose recognition and response. For clarification, the rescue kits are not distributed to the pupils, but rather to school personnel.

Program funding is also used to purchase opioid overdose prevention kits. Each kit is comprised of two mucosal atomizers, two syringes pre-filled with naloxone for use with the atomizers, a breathing mask, nitro gloves, and a zippered bag for containing the supplies. Naloxone has been successfully administered more than 2,700 times according to reports that have been submitted to the State. The actual number of reversals for which these responders have been responsible is likely to be substantially higher.
To carry out these objectives, the Department contracts with The Foundation for AIDS Research.

Payments to this vendor are for trainings, purchase of overdose prevention kits, and the contract's administrative expenses. These expenses include ordering the supplies, maintaining an inventory, interacting with the AIDS Institute, obtaining competitive pricing, providing reports on a regular basis, and working with pharmaceutical manufacturers and distributors. Overall program monitoring and assessing the achievement of goals involves review of monthly or quarterly narrative and statistical reports that are submitted, as well as onsite program and fiscal monitoring.

Budget and HSI Claiming Details

There are multiple funding sources for the program, two of which are Department appropriations, located within the Aids Institute major program. These are General Fund / Local Assistance appropriations, found in the Aid to Localities budget bill. The General Fund is the State's main operating fund.

Program estimates that 5% of gross expenditures relate to children age birth through 18. This figure will be used to approximate the total funding for children-related activity. Total expenses will be multiplied by 5% to establish the amount of funding related to children age birth through 18. This figure will then be multiplied by the current CHIP federal matching rate of 88% to calculate the amount of expenses that can be transferred to CHIP federal funding.

In the past, there has been a federal funding component of the program. The federal funds were an allocation and not a match. However, federal funds are not currently utilized. If federal funds are used prospectively, these funds will be excluded from the HSI, and only the State funds will be considered.

Periodic general ledger journal entries will be processed to move the qualified expenditures to CHIP federal funding. The expenses will be transferred from each fund source according to its percentage of the total funding. These transactions will be performed in the Statewide Financial System (SFS) and are approved within the Department, and at the Office of the State Comptroller (OSC). Backup documentation will be

included when the journal entries are processed. There is distinct coding in SFS for the opioid program funding, and for CHIP funding. There is also a specific program code for CHIP HSI expenditures, to distinguish them from other CHIP expenditures.

Upon SPA approval, a general ledger journal entry or entries will be processed to charge CHIP federal funding for HSI-related expenditures retroactive to April 1, 2016, the effective date of the SPA. Prospectively, journal entries will be processed to transfer HSI-related expenditures to CHIP federal funding.

Effective 1/2024 through 3/31/2027 the state is not claiming under CHPlus HSI due to implementation of the New York Health Equity Reform (NYHER) waiver.

3. Hunger Prevention Nutrition Assistance Program (HPNAP)

Program Details

The Hunger Prevention and Nutrition Assistance Program (HPNAP) was established in 1984 as a result of public health concerns about nutrition-related illnesses among persons in need of food assistance. The program is authorized by Chapter 53, Section 1 of the Laws of 2016, and is administered within the Department by the Center for Community Health, Division of Nutrition, Bureau of Nutrition Risk Reduction. HPNAP provides emergency food relief and nutrition services to food insecure populations in New York State.

HPNAP funding supports 44 Department contracts, which includes eight regional food banks and 36 direct service providers statewide. Through these contracts, approximately 422 million emergency meals are provided each year throughout the State. HPNAP works with an established network of more than 2,700 Emergency Food Relief Organizations (EFROs, including food banks, food pantries and soup kitchens, to leverage private and public partnerships.

The goal of the program is to help New Yorkers in need lead healthier, productive and self-sufficient lives, which aligns with the HSI objective of helping low-income populations. Access to a nutritious food supply directly improves the health of children. The program leads to increased access to safe and nutritious food and related resources, develops and provides nutrition and health education programs and empowers people to increase their independence from emergency food assistance programs.

Each regional food bank has a listing of the services they provide. These include safe and nutritious food to people in need; food transportation and food service equipment; assistance in gathering, processing and distributing unharvested fresh produce; nutrition and health information; and resources and guidance through workshops, handouts and site visits.

A component of the HPNAP program is the Just Say Yes to Fruits and Vegetables (JSY) program, a New York State program that offers nutrition education services to families with food insecurity. JSY is a collaboration between the Department and the New York State Regional Food Banks. It is designed to prevent over-weight/obesity and reduce long term chronic disease risks through the promotion of increased fruit and vegetable consumption. HPNAP and JSY work in partnership with EFPs to improve the health and nutrition status of people in need of food assistance in the State.

HPNAP maximizes service levels by utilizing the cost-efficient emergency food relief network, and by

closely monitoring contractor performance. All contractors receiving HPNAP funding must complete timely, accurate reports of monthly service levels, as specified in the HPNAP contract. In addition, HPNAP contract managers perform site visits for each of the program's 46 contractors each year.

Budget and HSI Claiming Details

The main funding source for the program is a Department appropriation, located within the Center for Community Health Program major program. The appropriation is General Fund / Local Assistance, and is in found in the Aid to Localities budget bill. The General Fund is the State's main operating fund.

During SFY 2015-16, the most recent period for which data are available, the number of children served age birth through 17 was 9,407,669, out of a total population served of 32,671,450. As such, it can be asserted that 28.7% of funding relates to children age birth through 18. Total HPNAP expenses will be multiplied by 28.7% to establish the amount of funding related to children age birth through 18. This figure will then be multiplied by the current CHIP federal matching rate of 88% to calculate the amount of expenses that can be transferred to CHIP federal funding.

The contracts associated with these programs use the State funded appropriation referenced above, but also a receive a small amount of federal funding through Nutrition-related grants. However, these federal funds are an allocation and not a match. For the purpose of the HSI, the federal funding allocation will be excluded and only the State funds will be considered.
Periodic general ledger journal entries will be processed to move the qualified expenditures to CHIP federal funding. These transactions will be performed in SFS, and are approved within the Department, and at OSC. Backup documentation will be included when the journal entries are processed. There is distinct coding in SFS for HPNAP funding, and for CHIP funding. There is also a specific program code for CHIP HSI expenditures, to distinguish them from other CHIP expenditures.

Upon SPA approval, a general ledger journal entry or entries will be processed to charge CHIP federal funding for HSI-related expenditures retroactive to April 1, 2016, the effective date of the SPA. Prospectively, journal entries will be processed to transfer HSI-related expenditures to CHIP federal funding.

Assurances

New York assures that the proposed HSI programs described above will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds.

New York also assures that all (100 percent) of the funds transferred (state and federal) are retained by the Opioid Drug Addiction and Opioid Overdose Prevention Program for Schools and the Hunger Prevention Nutrition Assistance Program (HPNAP).

4. Poison Control Centers

Program Details

DOH funds two regional poison control centers. New York City Regional Poison Control Center serves the Bronx, Brooklyn, Queens, Staten Island and Manhattan as well as Nassau, Suffolk and Westchester counties. Upstate New York Poison Center serves the 54 remaining counties of the state. Within DOH, the Office of Health Insurance Program's Division of Finance and Rate Setting administers the program.

The statutory authority for the program is contained in Sections 2500-d(7), 2807-j, and 2807- 1(1)(c)(iv) of the Public Health (PHL), which authorizes the Commissioner to make distributions from the Health Care Initiatives (HCI) Pool to the Regional Poison Control Centers. This HCI Pool funding is intended to assist the centers with meeting the operational costs of providing expert poison call response and poison consultation services on a 24/7 basis to health care professionals and the public statewide.

New York City Poison Control Center is available 24 hours a day, 7 days a week and provides treatment advice about exposures to poisons or questions about medicine safety. Pharmacists and nurses certified in poison information are there to give advice, and all calls are free and confidential. Translator services are provided in more than 150 languages.

Upstate New York Poison Center is also available 24 hours a day, 7 days a week, and assists the medical community and general public with poison emergencies by providing state of the art management expertise. The center is involved in poison emergency telephone management, poison information resources, public education, professional education and research and data collection. Calls are answered by specialists in poison information, registered nurses and pharmacists trained in toxicology. Specialists provide the most efficient and up-to-date poison information available. Physicians and toxicologists are on-call 24 hours a day for consultation purposes. Other specialists are available for consultation.

Budget and HSI Claiming Details

Each center receives a share of the $3 million annual grant. The grant is supported by a $3 million appropriation, found on lines 21 through 25 of page 461 in the SFY 2015-16 Enacted Budget for Aid to Localities. The funding source is a HCRA Resources Fund, which is a State special revenue fund. In both SFY 2014-15 and 2015-16, New York City Regional Poison Control Center received $1,851,130 and Upstate Poison Control Center received $1,148,870.

The amount of funding related to services for children is determined by the percentage of calls that pertain to children (aged birth through 18), multiplied by the total amount of funding the center received. Upstate Poison Control Center received 55,778 calls in SFY 2014-15 and 28,351, or approximately 50.8%, were related to children (aged birth through 18).

Based on the call data, the amount of funds used for children-related activity in SFY 2015-16 can be calculated at approximately $583,626 ($1,148,870 x 50.8%). NYC Regional Poison Control Center received 91,824 calls in calendar year 2014 and 32,436, or approximately 35.3%, were related to children (aged birth through 18). Accordingly, the amount of funds used for children- related activity in SFY 2015-16 can be calculated at approximately $653,449 ($1,851,130 x 35.3%).

In total, approximately $1,237,075 will fund children-related activity at the two poison control centers in SFY 2015-16 ($583,626 + $653,449). This annual amount ($1,237,075) will be used prospectively to approximate the total funding for children-related activity.

DOH will perform periodic general ledger journal entries to transfer the qualified Poison Control Center expenditures to CHIP federal funding. These transactions will be performed in SFS and must be approved within DOH, and at OSC. Backup documentation will be included when processing these entries. There is a unique program code in SFS for the Poison Control Centers program and CHIP, as well as a program code within CHIP dedicated to the HSI.

Upon SPA approval, a general ledger journal entry or entries will be processed to charge CHIP for HSI-related expenditures made during SFY 2015-16. The federal matching rate of 65% will be used for expenditures made from April 1, 2015 to September 30, 2015, and the federal matching rate of 88% will be used for expenditures effective October 1, 2015. Prospectively, periodic journal entries will be processed to transfer HSI-related expenditures to CHIP federal funding.

5. Sickle-Cell Screening

Program Details

The Sickle Cell Screening program provides transition services for adolescents and young adults with sickle cell disease and other hemoglobinopathies. The goal is to ensure that adolescents and young adults with sickle cell disease and other hemoglobinopathies are able to transition from pediatric health care and parent-directed control of their health to adult care and self-directed control of their health. There are four New York City hospitals currently receiving awards: Bronx Lebanon Hospital Center, Brookdale University Hospital, NYC HHC – Harlem Hospital, and New York Methodist Hospital.

Contractors are required to include both a pediatric and adult hematologist in the program, paid by the contracting institution. They must also employ a transition navigator (who may be paid on the grant) who works with the adolescent and young adult patients, their families, their schools and/or employers and the clinic/hospital to successfully transition from parental care to self-care and from pediatric to adult oriented medicine.

Budget and HSI Claiming Details

The funding source for the sickle cell screening program is General Fund – Local Assistance. The General Fund is the State's main operating fund. The appropriation is found on lines 30 and 31 of page 514 in the SFY 2015-16 Enacted Budget for Aid to Localities, and totals $213,400.

The program handles individuals aged birth through 18 as well as some over age 18, but not over 21. The original applications for the program requested a breakdown of the numbers of patients of specific age groups. The applications indicated that 630 of the 828 individuals served, or approximately 76.1%, were aged birth through 18. Therefore, for the purpose of the SPA, it is projected that 76.1% of total spending is for services related to children. This percentage will be used prospectively and will be multiplied by the total expenditures for a period in order to calculate the level of expenditures for services related to children.

DOH will perform periodic general ledger journal entries to transfer eligible Sickle Cell costs to CHIP federal funding. These transactions will be performed in SFS and must be approved within DOH, and at

OSC. Backup documentation will be included when processing these entries. There is a unique program code in SFS for the Sickle Cell program and CHIP, as well as a program code within CHIP dedicated to the HSI.

Upon SPA approval, a general ledger journal entry or entries will be processed to charge CHIP for HSI-related expenditures made during SFY 2015-16. The federal matching rate of 65% will be used for expenditures made from April 1, 2015 to September 30, 2015, and the federal matching rate of 88% will be used for expenditures effective October 1, 2015. Prospectively, periodic journal entries will be processed to transfer HSI-related expenditures to CHIP federal funding.

Assurances

New York assures that the two proposed HSI programs described above will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds.

New York also assures that all (100 percent) of the funds transferred (state and federal) are retained by the two Poison Control Centers and the Sickle-Cell Screening program.

2.3-TC **Tribal Consultation Requirements**- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

6.1.4.7. 1 Other (Describe)

Coverage for the FCEP Population:

Effective April 1, 2022, New York provides coverage from conception to the end of pregnancy (FCEP) for uninsured pregnant consumers in households with

income up to 218% FPL, plus 5% deduction, not otherwise eligible for Medicaid or CHIP.

Pregnant persons who are receiving services through the FCEP population shall continue to be eligible to receive services through the end of the month of birth, regardless of any subsequent changes in household income.

New York considers all services delivered to the pregnant persons through managed care during the pregnancy to support the health from conception to the end of pregnancy (FCEP) who at birth may be eligible as a targeted low-income child. New York claims CHIP federal financial participation (FFP) under this State Plan for managed care costs for the covered population through the last day of the month of birth.

Through New York's Medicaid and CHIP managed care organizations (MCOs), New York utilizes capitated payment arrangements for coverage of services including prenatal, labor and delivery, and postpartum services through the end of the month of birth. Claims for the postpartum period will begin the month after the month of birth.

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

The strategic objective for the CHPlus Program is to provide access to inpatient, outpatient, primary and preventive health care services to low income children by removing financial barriers and providing a medical home through a managed care product. The program has been successful in increasing enrollment. The same strategies that have worked, advertising and facilitated enrollment, will continue to be employed.

Strategic Objectives:

- Reduce the number of uninsured children
- Increase access to care
- Increase the use of preventive care

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

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

- Strategic Objective: Reduce the number of uninsured children
  - Performance Goal: Increase the number of children enrolled in CHIP by 5% over the next three years to reduce the number of uninsured children in New York State.

- Strategic Objective: Increase access to care
  - Performance Goal: Increase the percentage of children ages 6-12 enrolled in the CHIP program who receive follow up care after being prescribed an ADHD medication by 5% over the next three years.

- Strategic Objective: Increase the use of preventive care
  - Performance Goal: Increase the percentage of CHIP members ages 3-11 who received at least one well-care visit during the measurement year by 5% over the next three years.
  - Performance Goal: Increase the percentage of CHIP members who have completed the human papillomavirus vaccine by the age of the 13.
  - Performance Goal: Increase the percentage of CHIP members who were screened for clinical depression using a standardized instrument.

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that

State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

- Performance Goal: Increase the number of children enrolled in CHIP by 5% over the next three years to reduce the number of uninsured children in New York State.

  Performance Measure: Analysis of current population survey (CPS) data to ensure that the number of insured children in the State remains stable or increases through CHPlus and Medicaid enrollment, while both the number and percentage of uninsured children under age 19 below 400 percent of the poverty level continues to decrease.

  - CHPlus Health plans are responsible for submitting information to the Department regarding their enrollment. Reports can be generated from this information which include monthly enrollment reports (detailing new and ongoing enrollment and disenrollment, quarterly disenrollment reports, and quarterly reports on applicants' prior health insurance status to assess the potential for crowd-out.

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

- Performance Goal: Increase the percentage of children ages 6-12 enrolled in the CHIP program who receive follow up care after being prescribed an ADHD medication by 5% over the next three years.

  Performance Measure: The number of children between 6-12 years of age with a prescription for ADHD medication, who remained on the medication for 210 days, and had at least two follow up visits with a practitioner nine months after initiation phase.

  - The collection method for this measure switched to Electronic Clinical Data System in 2024. Based on the individual plan performance, the state will

continue to require plans to respond with acceptable quality improvement initiatives in those areas where problems or potential problems are identified through the Quality Assurance Reporting Requirements (QARR) reporting process.

- Performance Goal: Increase the percentage of CHIP members ages 3-11 who received at least one well-care visit during the measurement year by 5% over the next three years.

  Performance Measure: The number of children aged 3-11 who had at least one well-care visit during the measurement year.

- Performance Goal: Increase the percentage of CHIP members who have completed the human papillomavirus vaccine by the age of the 13.

  Performance Measure: The number of CHIP members who received the complete human papillomavirus vaccine series by the age of the 13

- Performance Goal: Increase the percentage of CHIP members who were screened for clinical depression using a standardized instrument.

  Performance Measure: The number of CHIP members aged 17 years old who were screened for clinical depression using a standardized instrument.

  - The collection method for these measures switched to Electronic Clinical Data System in 2024. Based on the individual plan performance, the state will continue to require plans to respond with acceptable quality improvement initiatives in those areas where problems or potential problems are identified through the QARR reporting process.
  - In 1994 New York State implemented the QARR as a tool to measure and manage the quality of care provided to New York residents. QARR is largely based on the measures published by the National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS) and has been collected for New York CHPlus health plans since 1998. The health plans report data from the previous year in June of the current year (i.e., data from calendar year 2022 was submitted in June 2023). This data includes quality, access, utilization and descriptive data collected from managed care plans licensed to operate in New York State. The measures are separated into four major categories: effectiveness of care; access and availability of care; uses of services; and health plan descriptive information. Additionally, health plans submit semi-annual and annual financial and utilization reports, annual progress reports (detailing marketing and enrollment outcomes), demographic characteristics of enrollees and utilization outcomes.

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**
Federal Fiscal Year	**2026-2027**
State's enhanced FMAP rate	**65%**
Benefit Costs	
Insurance payments	
Managed Care	$ 3,006,862,000
per member/per month rate	$ 271
Fee for Service	
Total Benefit Costs	**$ 3,006,862,000**
(Offsetting beneficiary cost sharing payments)	$ (50,000,000)
Net Benefit Costs	**$ 2,956,862,000**
Administration Costs	
Personnel	$ 2,000,000

General Administration	$ 39,900,000
Contractors/Brokers	
Claims Processing	
Outreach/Marketing	$ 1,600,000
Other (e.g., indirect costs)	$ 500,000
Health Service Initiatives (Early Intervention)	$ 99,569,379
Health Service Initiatives (HPNAP)	$ 10,619,000
Health Service Initiatives (Poison Control)	$ 1,077,380
Health Service Initiatives (Opioid)	$
Health Service Initiatives (Sickle Cell)	$ 165,000
Health Service Initiatives (Postpartum) *(pending)*	$
Health Service Initiatives (Total)	$ 111,430,759
Total Administration Costs	**$ 155,430,759**
10% Administative Cap	**$ 328,540,222**
Federal Share	$ 2,022,990,293.31
State Share	$ 1,089,302,465.63
Total Costs of Approved CHPlus Plan	**$ 3,112,292,759**