Table of Contents

State/Territory Name: New York

State Plan Amendment (SPA) #: 26-0022

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, MO 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

September 11, 2026

Amir Bassiri, Medicaid Director
Deputy Commissioner of the Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza
99 Washington Avenue, Suite 1715
Albany, NY 12211

Re: New York State Plan Amendment (SPA) – 26-0022

Dear Director Bassiri:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) NY-26-0022. This amendment proposes to amend the Title XIX (Medicaid) State Plan for State Method on Cost Effectiveness and Voluntary Participation in Employer-Based Group Health Plans to comply with Social Security Act §1906(a).

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and § 1906(a) of the Social Security Act. This letter informs you that New York's Medicaid SPA TN 26-0022 was approved on September 11, 2026, with an effective date of April 1, 2026.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the New York State Plan.

If you have any questions, please contact Melvina Harrison at (212) 616-2247 or via email at Melvina.Harrison@cms.hhs.gov.

Sincerely,

[redacted]

Megan K. Buck
Director, Division of Program Operations

Enclosures

cc: Regina Deyette

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 26 — 0022

2. STATE: NY

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 01, 2026

5. FEDERAL STATUTE/REGULATION CITATION
§ 1906(a) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 04/01/26-09/30/26 $ 0
b. FFY 10/01/26-09/30/27 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.22-C Pages: 1, 2

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.22-C Pages: 1, 2

9. SUBJECT OF AMENDMENT
Health Insurance Premium Payment Cost Effective Determination Method

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
June 30, 2026

15. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR CMS USE ONLY

16. DATE RECEIVED
June 30, 2026

17. DATE APPROVED
September 11, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
April 1, 2026

19. SIGNATURE OF APPROVING OFFI
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Megan K. Buck

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS

New York
1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Citation	Condition or Requirement
§1906(a) of the Act	State Method on Cost Effectiveness and Voluntary Participation in Employer-Based Group Health Plans

The determination of cost benefit for any health insurance policy is an evaluation of many varied but interrelated criteria. It is difficult to establish exact guidelines for cost benefit determinations that can be applied uniformly in all cases. Unless a person is already in poor health, whenever insurance is purchased, a risk is taken as to whether or not health expenses will be incurred. Therefore, cost benefit determinations must be made on an individual basis after the local district or Department of Health staff obtain information about the insurance policy and the individual applying for the premium payment. Due to mandatory managed care enrollment, cost effective determination is made by comparing the cost of the Medicaid managed care premiums to the cost of the employer-based group health plan.

Please note that for some cases, even after reviewing these criteria, the determination to pay for a health insurance policy may still be unclear. In these cases, the final decision will rest solely on the judgement of local district or Department of Health staff.

A. The following points should be considered at the time of determination and redetermination for coverage provided through employer-based group health plans.

1. Assess the types of medical services covered by the health insurance policies. The group or individual health plan must include a comprehensive set of benefits including: inpatient care, home health, emergency room, clinic, physician, pharmacy, substance abuse, psychiatric, ex-ray, lab and end of life care.

2. Determine the amount of deductible for the health insurance policy. If the deductible is equal to or exceeds the amount of the current IRS high-deductible amounts, the policy is considered as not cost effective.

3. If the criteria in 1. is met then, compare the Medicaid recipient's monthly share of the group or individual plan premium, yearly deductible, coinsurance, the cost of Medicaid wrap-around services which may include pharmacy, dental, vision, transportation, durable medical equipment, and an administrative fee to the monthly Medicaid managed care rate for the individual.

4. When the cost for the premium, yearly deductible, coinsurance, wrap services, and administrative fee for the premium assistance program added together is less than the cost of the Medicaid managed care rate for the individual, then the health plan meets the criteria for premium reimbursement.

B. Redetermination Review

1. A review must be completed at least yearly for all Health Insurance Premium Program (HIPP) enrollees . The yearly review will consist of:
   a. Verifying Medicaid eligibility;
   b. Verifying continued enrollment in Employer Sponsored Coverage;
   c. Completing a cost-effective analysis

2. If determined to be cost-effective, then re- determine HIPP eligibility at any point if:
   a. A change to the employee portion of the premium rate is identified;
   b. The Medicaid Managed Care premium rate is updated;
   c. There is a change to any Medicaid wrap around services or the administrative fee in the Cost-Effective calculation.
   d. There is a change (identified systematically or manually):
      i. In Medicaid eligibility;
      ii. In the services covered under the policy;
      iii. In the Medicaid eligible individuals on the policy.

3. Failure to submit required documents for redetermination may result in disenrollment from the HIPP program.

4. Failure to meet HIPP enrollment eligibility during redetermination, will result in HIPP disenrollment.

C. Purchasing or paying for health insurance coverage is deemed not cost- effective when:

1. Medicaid beneficiary is also enrolled in Medicare;
2. A court has ordered a non-custodial parent to provide medical insurance;
3. An individual or employee has been fully reimbursed for his/her payment of health care premiums; or
4. A recipient is also enrolled in a Medicaid managed care plan
5. A recipient is residing in a nursing home
6. The applicable deductible is above the IRS defined limit for a High Deductible Health Plan (HDHP).