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State/Territory Name: New York

State Plan Amendment (SPA) #: NY-24-0038 and
NY-24-0040

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

August 15, 2024

Gabrielle Armenia
Director, Division of Coverage and Enrollment
Office of Health Insurance Programs
State of New York Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237-0004

Dear Director Armenia:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendments (SPAs), NY-24-0038-CHIP and NY-24-0040-CHIP, submitted on March 29, 2024, with additional information submitted on August 13, 2024, have been approved.

Through SPA NY-24-0038-CHIP, New York makes technical updates to remove outdated references and clarify current practices. Effective April 1, 2023, New York aligns the strategic objectives and performance goals in section 9 of the state plan with those reported in the state's CHIP Annual Report. Effective June 1, 2023, the state modifies its renewal procedures to provide retroactive coverage to the first of the month for children whose families renew their coverage in the month following their prior 12-month enrollment period and select the same health plan, to avoid a gap in coverage. Effective January 1, 2024, New York updates its polices for continuous eligibility (CE) in section 4 of the state plan.

Through SPA NY-24-0040-CHIP, New York provides 12 months of CE coverage to individuals enrolled in its separate CHIP, pursuant to section 5112 of the Consolidated Appropriations Act, 2023 (CAA, 2023). Section 5112 of the CAA, 2023 amended titles XIX and XXI of the Social Security Act to require that states provide 12 months of CE for children under the age of 19 in Medicaid and CHIP. In New York, this provision applies to targeted low-income children and the from-conception-to-end-of-pregnancy (FCEP) population. Furthermore, New York confirms the state no longer disenrolls children from coverage due to late premium payments during or at the end of the CE period. This SPA has an effective date of January 1, 2024.

A copy of the approved CS21, CS27, and state plan pages are attached to be incorporated into the state's approved CHIP state plan.

Your Project Officer is Jennifer McIlvaine. She is available to answer your questions concerning this amendment and other CHIP-related matters. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: 667-290-9542
E-mail: Jennifer.McIlvaine@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Sarah deLone/

Sarah deLone
Director

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)) Gabrielle Armenia March 29, 2024 (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 to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010,

further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

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

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

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

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

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

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template

that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70) 2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))

3. **Methods of Delivery and Utilization Controls**- This section requires the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))
7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who

will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)

8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

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

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

Medicaid Expansion- CHIP SPA Requirements

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

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

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

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

Medicaid Expansion- Medicaid SPA Requirements

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

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

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

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

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

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd

Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

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

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

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

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

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

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

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

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

1.1-CHIP ☐ **DS** The State will provide dental-only supplemental coverage. Only States operating a separate program are eligible for this option. States choosing this option must also complete sections 4.1DS, 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: March 7, 2023
Effective Date: From conception to the end of pregnancy (FCEP) Coverage: April 1, 2022
Implementation Date: April 1, 2022

SPA #NY-23-0034A-CHIP

Submission Date: March 7, 2023
Effective Date From conception to the end of pregnancy (FCEP) Option (MMDL CS9): 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-23-0036-CHIP
Submission Date: February 23, 2023
Expansion of Postpartum period to 12-months
Effective Date: March 1, 2023
Implementation Date: March 1, 2023

SPA #NY-24-0037-CHIP – *Pending Approval*
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(s):
(Performance Goal Update: April 1, 2023
(Late Renewals) June 1, 2023,
(Continuous Eligibility) January 1, 2024

Implementation Date(s): April 1, 2023,
June 1, 2023,
January 1, 2024

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.

TN No: Approval Date Effective Date

A letter was mailed to all federally recognized tribes in New York State on March 14, 2024, notifying them of the proposed State Plan Amendment. A link was

provided in the letter for purposes of allowing the tribes to view the proposed State Plan Amendment. The tribes were given two weeks to provide comments/feedback on the proposed State Plan Amendment. No feedback was received within the prescribed timeframe.

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.

4.1.7 ☒ Access to or coverage under other health 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.

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, and 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 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.

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 renew 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.

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 incarceratedduring 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.

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,

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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.

Guidance: Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

5.3. **Strategies** Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program. (Section 2102(c)(1)) (42CFR 457.90)

New York established a facilitated enrollment program in 1999 to assist families in applying for public health insurance programs. We contracted with 41 community-based organizations including child advocacy groups, health care providers, rural health networks, perinatal networks and local governments to provide facilitated enrollment for CHPlus and Medicaid.

These organizations provide application assistance in community-based settings. Approximately $17 million was awarded to these organizations during the period April 1, 2010 through March 31, 2011 to support locally-tailored programs to develop and implement the necessary enrollment infrastructure. The facilitated enrollment program was re-procured in 2011 for contracts effective January 1, 2012. Approximately $15.3 million was awarded to 41 community-based organizations throughout the State.

Under the Affordable Care Act, NY State of Health is required to operate a Navigator Program to assist New Yorkers in enrolling in health insurance. Today, New York holds contracts with over 40 different agencies under that Navigator Program, that employ more

than 400 navigators who speak 40 languages and American Sign Language. Additionally, New York has Assistors and Marketplace Facilitated Enrollers that also provide outreach and enrollment assistance to consumers that may be eligible for Child Health Plus.

Navigators, Certified Application Counselors and Marketplace Facilitated Enrollers (collectively referred to as assistors) provide families with eligibility information, assist them in completing the application, help gather documentation and submit the application to NY State of Health for enrollment in CHPlus or Medicaid, for Modified Adjusted Gross Income (MAGI) populations. NY State of Health Assistors are available during evening and weekend hours, making enrollment more convenient for working families.

By removing some of the identified barriers to enrollment, the Department, through the assistors, can ensure that each child enters the system and receives services through the "right door", without families having to search for that door. In doing so, the Department has created a system that balances and coordinates federal and state statutes with the goal of enrolling targeted low-income children.

Because New York State has an integrated eligibility and enrollment system, much of the outreach work is geared toward promoting NY State of Health and the programs available through the Marketplace, including Medicaid and Child Health Plus. Specific outreach is not done for each program. In addition to a media campaign promoting NY State of Health, other campaign strategies include developing community partnerships, conducting outreach at community events, making presentations to provide education about NY State of Health, training community partners about the available health insurance options and raising public awareness about the programs available on NY State of Health. State and locally targeted outreach efforts are developed in conjunction with Navigators, Marketplace Facilitated Enrollers and Certified Application Counselors to address specific populations in need of health care coverage. Many Navigators Agencies target specific communities that are hard-to-reach.

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. Premiums:

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≤222% FPL $0
>222%-250%* $15, max per family $45
>250%-300% $30, max per family $90
>300%-350%* $45, max per family $135
>350%-400% $60, max per family $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.

* 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 period.

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.

Effective January 1, 2024, fully eligible subsidized enrollees who are within their 12month 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.

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.

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.

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 nonpayment 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.

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

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

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

- 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.

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: Perform quality improvement initiatives to enhance the performance of health plans in all areas of child and adolescent health.

- Measurement and reporting on these goals will happen through mainstay NYS quality measurement programs (e.g., Quality Assurance Reporting Requirements (QARR)) and through submission of data to the federal government (e.g., CMS' Medicaid and CHIP Program (MACPro) Portal).

- 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.

- The Department continues to have health plans report annually for the QARR on selected measures pertaining to the CHPlus program. Based on the individual plan performance, the State will continue to require plans to respond with acceptable quality improvement initiatives in those areas where problems or potential problems are identified through the QARR reporting process.

- 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: Perform quality improvement initiatives to enhance the performance of health plans in all areas of child and adolescent health.

  - Measurement and reporting on these goals will happen through mainstay NYS quality measurement programs (e.g., Quality Assurance Reporting Requirements (QARR)) and through submission of data to the federal government (e.g., CMS' Medicaid and CHIP Program (MACPro) Portal).

- 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.

- The Department continues to have health plans report annually for the QARR on selected measures pertaining to the CHPlus program. Based on the individual plan performance, the State will continue to require plans to respond with acceptable quality improvement initiatives in those areas where problems or potential problems are identified through the QARR reporting process.

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

CHILD HEALTH PLUS BUDGET SUMMARY

	Actual	*Projected*	*Projected*
Benefit Costs	**2022-23**	**2023-24**	**2024-25**
Insurance Payments	$1,218,498,165	$1,412,760,281	$1,524,902,505
Managed Care Payments	$961,971,735	$1,005,260,463	$1,050,497,184
Fee for Service			
Total Benefit Costs	$2,180,469,900	$2,418,020,744	$2,575,399,689
(Offsetting beneficiary cost sharing payments)	($43,654,000)	($43,654,000)	($43,654,000)
Net Benefit Costs	$2,136,815,900	$2,374,366,744	$2,531,745,689
RRSY Benefit Cost (Effective 4/1/23)	$116,304	$237,894	$248,707
Net Benefit Costs Plus Benefit Expansion Cost	$2,136,932,204	$2,374,604,638	$2,531,994,396
Administration Costs	**2022-23 Actual**	**2023-24 Projected**	**2024-25 Projected**
Personnel	$2,830,547	$2,915,463	$3,002,927
General Administration	$21,481,520	$49,848,617	$29,207,238
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs	$983,178	$1,012,673	$1,043,053
Other (e.g., indirect costs)	$365,249	$376,206	$387,493
Health Services Initiatives	$140,154,001	$209,692,000	$247,692,000
Total Administration Costs	$165,814,495	$263,844,960	$281,332,711
10% Administrative Cap	$237,436,912	$263,844,960	$281,332,711
Federal Title XXI Share	$1,626,027,330	$1,721,918,169	$1,828,662,620
State Share	$748,341,786	$916,531,429	$984,664,488
TOTAL COSTS OF APPROVED CHIP PLAN	$2,374,369,116	$2,638,449,598	$2,813,327,107

CHIP Eligibility

State Name: New York

OMB Control Number: 0938-1148

Transmittal Number: NY - 24 - 0040

Separate Child Health Insurance Program Non-Financial Eligibility - Non-Payment of Premiums	**CS21**
42 CFR 457.570	
Non-Payment of Premiums	
Does the state impose premiums or enrollment fees?	Yes
Can non-payment of premiums or enrollment fees result in loss of CHIP eligibility?	No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

CHIP Eligibility

State Name: New York

OMB Control Number: 0938-1148

Transmittal Number: NY - 24 - 0040

Separate Child Health Insurance Program
General Eligibility - Continuous Eligibility **CS27**

2107(e)(1)(K) of the SSA and 42 CFR 457.342 and 435.926; 2107(e)(1)(J) and 1902(e)(16) of the SSA

Mandatory 12-Month Postpartum Continuous Eligibility in CHIP for States Electing This Option in Medicaid

At state option in Medicaid, states may elect to provide continuous eligibility for an individual's 12-month postpartum period consistent with section 1902(e)(16) of the SSA. If elected under Medicaid, states are required to provide the same continuous eligibility and extended postpartum period for pregnant individuals in its separate CHIP. A separate CHIP cannot implement this option if not also elected under the Medicaid state plan.

State elected the Medicaid option to provide continuous eligibility through the 12- month postpartum period: Yes

☒ The state assures the extended postpartum period available to pregnant targeted low-income children or targeted low-income pregnant women under section 2107(e)(1)(J) of the SSA is provided consistent with the following provisions:

- ☒ Individuals who, while pregnant, were eligible and received services under the state child health plan or waiver shall remain eligible throughout the duration of the pregnancy (including any period of retroactive eligibility) and the 12-month postpartum period, beginning on the day the pregnancy ends and ending on the last day of the 12th month consistent with paragraphs (5) and (16) of section 1902(e) of the SSA

☒ Continuous eligibility is provided to targeted low-income children who are pregnant or targeted low-income pregnant women (if applicable) who are eligible for and enrolled under the state child health plan through the end of the 12-month postpartum period who would otherwise lose eligibility because of a change in circumstances, unless:

- ■ The individual or representative requests voluntary disenrollment.
- ■ The individual is no longer a resident of the state.
- ■ The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to the individual.
- ■ The individual dies.

Unlike continuous eligibility for children, states providing the 12-month postpartum period may not end an individual's continuous eligibility due to becoming eligible for Medicaid.

- ☒ Consistent with section 2107(e)(1)(J) of the SSA, the state assures that continuous eligibility is provided through an individual's pregnancy and 12-month postpartum period regardless of an individual becoming eligible for Medicaid.

☒ Benefits provided during the 12-month postpartum period must be the same scope of comprehensive services consistent with the benefit package elected by the state under section 2103(a) of the SSA that is available to targeted low-income children and/or targeted low-income pregnant women and may include additional benefits as described in Section 6 of the CHIP state plan.

CHIP Eligibility

Mandatory Continuous Eligibility for Children

The CHIP Agency must provide that children who have been determined eligible under the state plan shall remain eligible, regardless of any changes in the family's circumstances, for a 12-month continuous eligibility period.

☒ Consistent with section 2107(e)(1)(K) of the SSA, the state assures that continuous eligibility is provided to its targeted low-income children for a duration of 12 months, regardless of any changes in circumstances, unless:

- ■ The child attains age 19.
- ■ The child or child's representative requests voluntary disenrollment.
- ■ The child is no longer a resident of the state.
- ■ The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to child or child's representative.
- ■ The child dies.
- ■ The child becomes eligible for Medicaid.

The state elects to provide coverage to the from-conception-to-end-of-pregnancy (FCEP) population (otherwise known as the "unborn"). Yes

☒ The state assures continuous eligibility for the FCEP population is provided in the same manner as continuous eligibility for other targeted low-income children, except for the duration of the continuous eligibility period.

The duration of continuous eligibility for the FCEP population depends on whether a state enrolls the birthing parent into Medicaid for coverage of labor and delivery or pays for the delivery under CHIP. The state conducts at least one of the following actions upon birth of the child:

CHIP pays for labor and delivery and the state screens the child for potential eligibility for Medicaid. Yes

Emergency Medicaid pays for labor and delivery and the state deems the newborn eligible for Medicaid and ends the continuous eligibility period in CHIP. No

PRA Disclosure Statement

V.20240322