Table of Contents

State/Territory Name: New York

State Plan Amendment (SPA) #: NY-25-0042-CHIP

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

June 17, 2025

Gabrielle Armenia, Director
Division of Eligibility and Marketplace Integration
New York State Department of Health
One Commerce Plaza, 8th Floor
Albany, NY 12237

Dear Director Armenia:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) NY-25-0042, submitted March 25, 2025, has been approved. NY-25-0042 has an effective date of January 1, 2025.

Through this SPA, New York expands coverage under its existing Home and Community Based Services (HCBS) coverage category specifically for services related to children and youth with a physical health, developmental disability, and/or mental health diagnosis that are at risk of institutionalization. These services permit children and youth to remain at home or to return home or to the community from a higher level of care.

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 Mary Beth Hance, Acting Director, Division of State Coverage Programs, at (410) 786-4299. 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))/s/ Gabrielle Armenia (Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

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

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

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

Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

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

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)
- Added new assurances related to the coverage of vaccines (Sections 2103(c)(1)(D) and (c)(12));

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

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

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

information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

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

The template includes the following sections:

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

6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary- approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))
7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality-of-care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre- existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low-income children under the plan for maximizing health benefits coverage for other low-income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low-income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart
    I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for

states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

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

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

Medicaid Expansion- CHIP SPA Requirements

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

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

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

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

Medicaid Expansion- Medicaid SPA Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to

be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan

Original Submission

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

SPA #1

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

SPA #2

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

SPA #3

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

SPA #4

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

SPA #5 (compliance)

Submission date:	March 31, 2003

SPA #6 (renewal process)

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

SPA #7

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

SPA #8

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

SPA #9

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

SPA # 10

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

SPA # 11

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

SPA # 12

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

SPA # 13

Submission date:	June 30, 2009
Effective date:	April 1, 2009
Implementation date:	April 1, 2009

SPA # 14

Submission date:	July 6, 2009
Effective date:	July 1, 2009
Implementation date:	July 1, 2009

SPA # 15

Submission date:	March 29, 2010
Effective date:	April 1, 2009
Implementation date:	April 1, 2009

SPA # 16

Submission date:	March 21, 2011
Effective date:	April 1, 2010
Implementation date:	April 1, 2010

SPA # 17

Submission date:	May 20, 2011
Effective date (Enrollment Center):	June 13, 2011
Effective date (Medical Homes Initiative):	October 1, 2011
Implementation date:	June 13, 2011

SPA # 18

Submission date:	September 20, 2011
Effective date:	August 25, 2011
Implementation date:	August 25, 2011

SPA # 19

Submission date:	March 22, 2012
Effective date (Medicaid Expansion):	November 11, 2011
Implementation date:	November 11, 2011

SPA # 20

Submission date:	March 31, 2014
Effective date (autism benefit):	April 1, 2013
Effective date (other ACA changes)	January 1, 2014
Implementation date:	April 1, 2013 and January 1, 2014

SPA #21

Submission date:	March 31, 2015
Effective date:	April 1, 2014
Implementation date:	April 1, 2014

SPA #NY-16-0022- C-A

Submission date:	March 28, 2016
Effective date: (HSI for Poison Control Centers and Sickle Cell Screening):	April 1, 2015
Effective date (Ostomy Supplies):	May 1, 2015
Implementation date:	April 1, 2015 and May 1, 2015

SPA #NY-17-0023 – C - A

Submission date:	March 31, 2017
Effective date (HSI Opioid Drug Addiction and Opioid Overdose Prevention Program for Schools, Hunger Prevention Nutrition Assistance Program (HPNAP)	April 1, 2016
Effective date (Coverage for Newborns):	January 1, 2017
Implementation date:	April 1, 2016 and January 1, 2017

SPA #NY – 19-0024

Submission date:	March 27, 2019
Effective date (Transition of Children to NY State of Health):	
Effective Date (Allowing Children to Recertify on the Last Day of the Month of their Enrollment Period):	
Implementation Date:	April 1, 2018

SPA # NY -19-0025

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

SPA #NY- 20-0026– *Pending Approval*

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

SPA #NY- 20-0027– *Pending Approval*

Submission Date:	March 31, 2020
Effective Date: Compliance with Managed Care Regulations	April 1, 2019
Implementation Date:	April 1, 2019

SPA #NY- 20-0028

Submission Date:	March 31, 2020
Effective Date: Disaster Relief Provisions	March 1, 2020
Implementation Date:	March 1, 2020

SPA #NY- 20-0029

Submission Date:	June 25, 2020
Effective Date: (HSI Early Intervention Program) Provisions	April 1, 2020
Implementation Date:	April 1, 2020

SPA #NY- 21-0030 – *Pending Approval*

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

SPA #NY- 21-0031-CHIP

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

SPA #NY- 21-0032-CHIP

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

SPA #NY-22-0033-CHIP

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

SPA #NY-23-0034-CHIP

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

SPA #NY-23-0034A-CHIP

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

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

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

SPA #NY-24-0036-CHIP

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

SPA #NY-24-0037-CHIP

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

SPA #NY-24-0038-CHIP

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

SPA #NY-24-0039-CHIP

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

SPA #NY-24-0040-CHIP

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

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

Submission Date:	March XX, 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 XX, 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

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.

Consistent with New York's approved tribal consultation policy, a letter was mailed to all federally recognized tribes in New York State on March 10, 2025 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 comments were received.

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

Guidance: Home and community-based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

6.2.12. ☒ Home and community-based health care services (Section 2110(a)(14))

Home and Community Based Services (HCBS)

Support and provide services to children/youth in non-institutionalized settings that enable them to remain at home and in the community or for children/youth being discharged from an institutional setting who require these services to safely return to their home and community.

Children/youth who are eligible for HCBS must have a physical health, developmental disability, and/or mental health diagnosis with related significant needs that place them at risk of hospitalization or institutionalization, or that HCBS is needed for the child/youth to return safely home and to their community from a higher level of care. (Institutionalization refers to children/youth at risk of being admitted to a higher level of care such as out-of-home residential settings, hospitalization, ICF-I/ID, or nursing facility).

HCBS eligibility is comprised of three components:
1) target criteria,
2) risk factors, and
3) functional criteria.

The HCBS eligibility groups are as follows:

1. Level of Care (LOC): children/youth that meet institutional placement criteria
There are four subgroups for children/youth within the LOC group:
1) Serious Emotional Disturbance (SED)*
2) Medically Fragile Children (MFC)*
3) Developmental Disability (DD) and Medically Fragile*
4) Developmental Disability (DD) and Foster Care*

Services are intended to assist children/youth in being successful at home, in school, and in other natural environments to help maintain them in the community and avoid higher levels of care and out-of-home placements. Services are family-

driven, youth-guided, and culturally and linguistically appropriate. Services are individualized to meet the physical health, developmental, and behavioral health needs of each child/youth. Services are provided in a flexible, complimentary package that evolves over time to meet the changing needs of the child/youth.

* Children who may be eligible for HCBS under Medicaid will be referred to Medicaid. If a CHPlus enrollee is determined to be Medicaid eligible they will no longer be eligible for Child Health Plus and would receive HCBS under the Medicaid 1915c Children's Waiver. Only CHPlus enrolled children/youth who are determined ineligible for Medicaid will be able to receive HCBS through the CHPlus program.

Home Health Care Services

Scope of Coverage: The care and treatment of a covered person who is under the care of a physician but only if hospitalization or confinement in a skilled nursing facility would have been otherwise required if home care was not provided, the service is approved in writing by such physician, and the plan covering the home health service is established by the Department.

Level of Coverage: Home care shall be provided by a certified home health agency possessing a valid certificate of approval issued pursuant to Article 36 of the Public Health Law. Home care shall consist of one or more of the following: part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.); part-time or intermittent home health aide services which consist primarily of caring for the patient; physical, occupational or speech therapy if provided by the home health agency; medical supplies, drugs and medications prescribed by a physician; and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered or provided if the covered person had been hospitalized or confined in a skilled nursing facility. A minimum of forty such visits must be provided in any calendar year.

Diabetic Education and Home Visits

Scope of Coverage: Diabetes self-management education (including diet); reeducation or refresher. Home visits for diabetic monitoring and/or education.

Level of Coverage: Limited to medically necessary visits where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management or where reeducation is necessary. May be provided by a physician or other licensed health care provider legally

authorized to prescribe under Title 8 of the Education Law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law and shall be limited to group settings wherever practicable.

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

- Planned use of funds, including:
    - Projected amount to be spent on health services;
    - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
    - Assumptions on which the budget is based, including cost per child and expected enrollment.

    - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low-income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
    - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
    - Total 1-year cost of adding prenatal coverage
    - Estimate of unborn children covered in year 1

STATE: NY	FFY Budget	FFY Budget	FFY Budget
Federal Fiscal Year	**2023-2024**	**2024-2025**	**2025-2026**
State's enhanced FMAP rate	**65%**	**65%**	**65%**
Benefit Costs			
Insurance payments			
Managed Care	$ 2,034,739,358	$ 2,126,302,630	$ 2,221,986,248
per member/per month rate	$ 179	$ 187	$ 195
Fee for Service			
Total Benefit Costs	**$ 2,034,739,358**	**$ 2,126,302,630**	**$ 2,221,986,248**
(Offsetting beneficiary cost sharing payments)	$ (49,502,745)	$ (50,000,000)	$ (50,000,000)
Net Benefit Costs	**$ 1,985,236,613**	**$ 2,076,302,630**	**$ 2,171,986,248**
Cost of Proposed SPA Changes - HCBS Benefit	**$ -**	**$ 2,218,757**	**$ 2,958,342**
Administration Costs			
Personnel	$ 2,425,281	$ 2,498,039	$ 2,572,981
General Administration	$ 35,833,981	$ 31,260,013	$ 31,168,813
Contractors/Brokers			
Claims Processing			
Outreach/Marketing	$ 1,325,089	$ 1,600,000	$ 1,600,000
Health Service Initiative (Early Intervention)	$ 64,720,096	$ 64,720,096	$ 64,720,096
Health Service Initiative (HPNAP)	$ 6,709,950	$ 6,709,950	$ 6,709,950
Health Service Initiative (Poison Control)	$ 700,297	$ 700,297	$ 700,297
Health Service Initiative (Opioid)	$ 100,000	$ 100,000	$ 100,000
Health Service Initiative (Sickle Cell)	$ 100,000	$ 100,000	$ 100,000
Other	$ 526,163	$ 541,948	$ 558,206
Total Administration Costs	**$ 112,440,857**	**$ 108,230,343**	**$ 108,230,343**
10% Administrative Cap	$ 220,581,846	$ 230,700,292	$ 241,331,805
Cost of Proposed SPA Changes (HCBS)	**$ -**	**$ 2,218,757**	**$ 2,958,342**
Federal Share	$ 1,363,490,355.78	$ 1,421,388,624.20	$ 1,484,063,706.40
State Share	$ 734,187,114.65	$ 765,363,105.34	$ 799,111,226.52
Total Costs of Approved CHPlus Plan	**$ 2,097,677,470**	**$ 2,186,751,730**	**$ 2,283,174,933**