DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

November 14, 2024

Amir Bassiri
Medicaid Director, Deputy Commissioner
New York Department of Health
Empire State Plaza, Corning Tower, Room 1466
Albany, NY 12237

Dear Amir Bassiri,

The Centers for Medicare & Medicaid Services (CMS) is approving New York's request for an amendment to the "Medicaid Redesign Team" (MRT) section 1115 demonstration (Project Numbers 11-W-00114/2 and 21-W-00078/2), in accordance with section 1115(a) of the Social Security Act (the "Act"). Approval of this request will provide expenditure authority to allow the state to provide continuous eligibility to all children (including children in the state's separate CHIP program) up to age six, from birth through the end of the month in which their sixth birthday falls. New York has assured that it will provide continuous eligibility through a manual process to all Medicaid and separate CHIP children up to age six whose continuous eligibility period cannot be provided systematically. The authority is effective from the date of this approval and will remain in effect through the rest of the demonstration approval period, which is set to expire March 31, 2027.

CMS's approval of this section 1115(a) demonstration amendment is subject to the limitations specified in the attached expenditure authority, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The STCs in Attachment R of this letter should be considered as part of the broader set of STCs that were approved on January 9, 2024 for the MRT demonstration and will be incorporated into the full STCs at the next approval action for this demonstration. All continuous eligibility requirements in statue and regulations, as well as CMS guidance explaining continuous eligibility apply to this demonstration, unless the governing expenditure authorities and STCs state that a particular rule or policy does not apply.

Extent and Scope of Demonstration Amendment

New York will provide continuous eligibility to these populations for the specified length of time:

- Continuous eligibility for all children, including separate CHIP recipients, up to age six, through the end of the month of their sixth birthday, regardless of changes in circumstances that would otherwise cause a loss of eligibility.

Continuous eligibility is intended to support consistent coverage and continuity of care by keeping children under age six enrolled, regardless of changes in circumstances that would otherwise cause a loss of eligibility or other changes that would affect eligibility, such as a change in income. Expanding continuous eligibility beyond what is allowable in the Medicaid state plan is likely to assist in promoting the objectives of Medicaid and CHIP by minimizing coverage gaps and helping to maintain continuity of access to program benefits for these populations, thereby improving health outcomes, and reducing churn. In 2018, one in ten Medicaid/CHIP enrollees disenrolled and reenrolled in Medicaid/CHIP in under one year.[1] Continuous eligibility also supports reducing administrative costs resulting from churn; estimates from 2015 show that the administrative cost of one instance of churn (disenrolling and reenrolling) for one individual ranges from $400-$600.[2] Continuous coverage is also likely to be an important driver of reducing the rate of uninsured and underinsured individuals.[3] To facilitate access to and continuity of care, and recognizing that beneficiaries may not be aware of their continued coverage[4], the amendment requires that the state have procedures and processes in place to provide individuals who qualify for a continuous eligibility period that exceeds 12 months an annual reminder of continued eligibility.

Budget Neutrality[5] / CHIP Allotment Neutrality

CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. The demonstration amendment is projected to be budget neutral to the federal government. The state will be held to the budget neutrality monitoring and reporting requirements as outlined in the attachment and current STCs. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 demonstration approvals.

Under this approval, projected demonstration expenditures associated with the new continuous eligibility population will be treated as hypothetical for the purposes of budget neutrality, and the WOW baselines have been trended forward to determine the maximum expenditure authority for the approval period.

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[1] Corallo B, Garfield R, Tolbert J, Rudowitz R. Medicaid enrollment churn and implications for continuous Coverage Policies | KFF. KFF. Published December 15, 2021. https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/

[2] Swartz K, Short PF, Graefe DR, Uberoi N. Reducing Medicaid churning: Extending eligibility for twelve months or to end of calendar year is most effective. Health Affairs. 2015;34(7):1180-1187. doi:10.1377/hlthaff.2014.1204

[3] A September 2023 State Health Official letter provides background on the importance of continuous eligibility in preventing interruptions that impede access to health coverage to support better short- and long-term health outcomes, and describes policies related to implementing continuous eligibility under the Consolidated Appropriations Act, 2023 (CAA, 2023) amendments.

[4] McIntyre A, Smith RB, Sommers BD. Survey-Reported Coverage in 2019-2022 and Implications for Unwinding Medicaid Continuous Eligibility. *JAMA Health Forum.* 2024;5(4):e240430. doi:10.1001/jamahealthforum.2024.0430; https://jamanetwork.com/journals/jama-health-forum/fullarticle/2817285.

[5] For more information on CMS's current approach to budget neutrality, see https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html

Under this amendment, the state will be subject to a limit on the amount of federal title XXI funding that the state may receive on allowable demonstration expenditures during the demonstration period. CMS has long required, as a condition of demonstration approval, that demonstrations be "allotment neutral," meaning the federal title XXI funds for the state's CHIP program are restricted to the state's available allotment and reallocated funds. The state is eligible to receive title XXI funds for the demonstration population as described in attached STC 1.2, up to the amount of its title XXI allotment. Title XXI funds must be first used to fully fund costs associated with CHIP state plan populations. The demonstration expenditures are limited to remaining funds.

Monitoring and Evaluation Requirements

States are required to conduct systematic monitoring and robust evaluation of section 1115 demonstrations in accordance with the STCs. For the continuous eligibility policy, monitoring reporting must provide metrics data for enrollment and ex parte renewals, and narrative updates on the successes and challenges of collecting and providing applicable information as outlined in the STCs. States must also evaluate the impact of the policy on all relevant populations, appropriately tailored for the specific time span of eligibility. Evaluation hypotheses must focus on, but may not be limited to, enrollment continuity, utilization of age-appropriate preventive care, inpatient admissions and avoidable emergency care, and health disparities.

Consideration of Public Comments

The federal comment period was open from June 27, 2024 through July 26, 2024 for the demonstration amendment request submitted June 10, 2024, during which CMS received 21 comments. These comments were submitted by various community and advocacy organizations. The commenters were unanimously in support of this amendment.

After carefully reviewing the proposal and the public comments received during the federal comment period, and all other relevant materials provided by the state, CMS has concluded that the approval of this amendment is likely to assist in promoting the objectives of Medicaid.

Other Information

CMS's approval of this demonstration project is conditioned upon compliance with the previously approved expenditure authorities and special terms and conditions, which set forth in detail the nature, character and extent of anticipated federal involvement in the project.

In addition, the approval is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer is Jonathan Morancy. He is available to answer any questions concerning this amendment. Jonathan's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-25-26
7500 Security Boulevard

Baltimore, Maryland 21244-1850
Email: Jonathan.Morancy@cms.hhs.gov

We appreciate your state's commitment to addressing continuous eligibility, and we look forward to our continued partnership on the MRT demonstration. If you have any questions regarding this approval, please contact Ms. Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

Enclosure

cc: Melvina Harrison, Monitoring Lead, Medicaid and CHIP Operations Group

Attachment R

CENTERS FOR MEDICARE & MEDICAID SERVICES

Expenditure Authority

NUMBER: **11-W-00114/2 and 21-W-00078/2**

TITLE: **New York Medicaid Redesign Team (MRT)**

AWARDEE: **New York State Department of Health**

Title XIX Expenditure Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by New York for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration, be regarded as expenditures under the state's title XIX plan. The following expenditure authority must only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable New York to implement the section 1115 demonstration amendment. All other requirements of the Medicaid program, including current and future CMS guidance for continuous eligibility, as expressed in law, regulation, and policy statements must apply to these expenditures, unless identified as not applicable below.

Continuous Eligibility. Expenditures for continued state plan benefits for individuals who have been determined eligible as specified in Table 1 of STC 1.2, who are not otherwise excluded under STC 1.3 for the applicable continuous eligibility period, and who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 1.4.

Title XXI Expenditure Authority

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A), state expenditures described below, shall, for the period of this demonstration, and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's title XXI plan. The following expenditure authority must only be implemented consistent with the approved STCs and shall enable New York to implement the section 1115 demonstration amendment. All other requirements of the CHIP program, including current and future guidance for continuous eligibility, as expressed in law, regulation, and policy statements must apply to these expenditures, unless identified as not applicable below.

Continuous Eligibility. Expenditures for continued state plan benefits for individuals who have been determined eligible under groups specified in Table 1 of STC 1.2, who are not otherwise excluded under STC 1.3 for the applicable continuous eligibility period who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 1.4.

SPECIAL TERMS AND CONDITIONS

1. Eligibility and Enrollment

1.1 Continuous Eligibility: Eligible populations, identified in STC 1.2, will receive continuous eligibility through the demonstration. The state is authorized to provide continuous eligibility for the populations for the durations specified in Table 1 below, regardless of the delivery system through which these populations receive Medicaid and separate CHIP (S-CHIP) benefits.

a. For individuals who qualify for continuous eligibility, the continuous eligibility period begins on the effective date of the individual's eligibility under 42 CFR 435.915 or 457.340(g), or the effective date of the most recent redetermination.

b. Because individuals are continuously eligible regardless of changes in circumstances, the state does not need to conduct renewals or redeterminations of eligibility consistent with 42 CFR 435.916 and 435.919 or 457.343 and 457.344 for individuals who qualify for continuous eligibility until the end of the individual's continuous eligibility period, except in the limited circumstances of a beneficiary meeting one of the exceptions outlined in STC 1.4**.**

c. At the end of the continuous eligibility period, New York must conduct a renewal of Medicaid or S-CHIP eligibility and consider eligibility on all bases consistent with 42 CFR 435.916(d)(1) or 42 CFR 457.343 prior to terminating coverage. Individuals determined eligible on another basis at the end of the continuous eligibility period will be moved to the appropriate group at that time. Individuals determined eligible on another basis resulting in a reduction of Medicaid eligibility or services or increase in cost sharing or premiums will be provided advance notice of termination in accordance with 42 CR 435.917 and 42 CFR 431, Subpart E. Individuals determined ineligible for Medicaid or S-CHIP on all bases will be provided advance notice of termination in accordance with 42 CR 435.917 and 42 CFR 431, Subpart E and 42 CFR 457.110 and 457.340 and assessed for potential eligibility for other insurance affordability programs in accordance with 42 CFR 435.916(d)(2).

1.2 Populations and Duration: The state is authorized to provide continuous eligibility for the following populations for the associated durations.

a. Children up to age six. Except as provided in STC 1.4**,** individuals age zero through the end of the month of their sixth birthday, who enroll in Medicaid or S-CHIP shall qualify for continuous eligibility until the end of the month in which their sixth birthday falls.

Table 1: Eligible Populations and Associated Duration for Continuous Eligibility (CE)	
Population	**Duration of CE**
Children (including S-CHIP) up to age 6	Until the end of the month of their 6th birthday

1.3 Eligibility Exclusions: The following children are excluded from receiving continuous eligibility:

a. Have only established Medicaid eligibility as medically needy (as set forth in section 1902(a)(10)(C) of the Act),

b. Have been determined presumptively eligible for Medicaid or S-CHIP but have not yet received an eligibility determination based on a regular application, or
c. Upon the adult and child's renewal are determined to only be eligible for Medicaid based on transitional medical assistance (as set forth in section 1925 of the Act).

1.4 Exceptions to Continuous Eligibility: Notwithstanding STC 1.2, if any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid or S-CHIP eligibility shall be redetermined or terminated:

a. The beneficiary attains the age limit of the continuous eligibility period or eligibility group (if applicable);
b. The beneficiary is no longer a New York resident;
c. The beneficiary or their representative requests termination of eligibility;
d. The beneficiary dies;
e. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual; or
f. For S-CHIP, the child becomes eligible for Medicaid. The state must provide the child with a new 12-month continuous eligibility period based on the date they were determined eligible for Medicaid.

1.5 Beneficiary-Reported Information and Periodic Data Checks:

a. The state must have procedures designed to ensure that beneficiaries can make timely and accurate reports of any change in circumstances that may affect their continuous eligibility as outlined STC 1.4 (such as a change in state residency) and are able to report other information relevant to the state's implementation or monitoring and evaluation of this demonstration, such as changes in income. The beneficiary must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).
b. For individuals who qualify for a continuous eligibility period that exceeds 12 months, the state must continue to attempt to verify residency at least once every 12 months. The state should follow its typical processes that it would otherwise use to verify continued residency at renewal if continuous eligibility was not available for these individuals.
c. Additionally, at least once every 12 months, the state must follow its typical processes to attempt to confirm the individual is not deceased, consistent with the data sources outlined in the state's verification plan(s) and/or confirmed by the household per 42 CFR 435.952(d) or 457.380. The state must redetermine eligibility if the state receives information that indicates a change in state residency or that the individual is deceased, verifying the change consistent with 42 CFR 435.919 or 457.344 and in accordance with 42 CFR 435.940 through 435.960 and the state's verification plan developed under 42 CFR 435.945(j) or 457.380.
d. Because individuals are receiving continuous eligibility beyond their eligibility period, the state does not need to complete the individual's annual renewal or act on changes in circumstances that would otherwise affect eligibility, except as detailed in STC 1.4, until the end of the individual's continuous eligibility period. Additionally, if the state obtains information about changes that may affect eligibility (e.g., change

in income), they are not permitted to use the information related to the change to end the continuous eligibility period early and terminate coverage, unless the change relates to one or more of the exceptions detailed in STC 1.4.

1.6 Annual Updates to Beneficiary Contact Information: For all continuous eligibility periods longer than 12 months, the state must have procedures and processes in place to accept and update beneficiary contact information and must attempt to update beneficiary contact information on an annual basis, which may include examining data sources annually and partnering with managed care organizations to encourage beneficiaries to update their contact information. The state is reminded that updated contact information obtained from third-party sources with an in-state address is not an indication of a change affecting continuous eligibility. Contact information with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to state residency, but without additional follow up by the state per 42 CFR 435.952(d) or 457.380(f), the receipt of this third-party data is not sufficient to make a definitive determination that beneficiaries no longer meet state residency requirements.

1.7 Annual Reminders of Continued Eligibility: The state must have procedures and processes in place to provide individuals who qualify for a continuous eligibility period that exceeds 12 months an annual reminder of continued eligibility. The annual reminder of continued eligibility must:

a. Be written in plain language;
b. Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with 42 CFR 435.905(b); and
c. If provided in electronic format, comply with requirements for electronic notices in 42 CFR 435.918.

The annual reminder of continued eligibility must, at a minimum, include:

d. An explanation of the individual's continued eligibility, including the end date of the continuous eligibility period;
e. The circumstances under which the individual must report, and procedures for reporting, any changes that may affect the individual's continuous eligibility;
f. Basic information on the level of benefits and services available as described at 42 CFR 435.917(b)(1)(iv); and
g. If the beneficiary's eligibility is based on having household income at or below the applicable MAGI standard, the content regarding non-MAGI eligibility described at 42 CFR 435.917(c).

1.8 Cost Sharing within Continuous Eligibility: Individuals receiving continuous eligibility enrolled in this demonstration may be subject to cost sharing responsibilities, such as monthly premiums and co-payments, to the extent allowable under title XIX and/or XXI requirements or as approved under current section 1115 demonstration authority**.** However, beneficiaries may not be disenrolled from this demonstration for failure to pay a premium during the individual's continuous eligibility period approved in the demonstration.

2. Monitoring and Reporting Requirements

2.1 Performance Metrics: For the continuous eligibility policy, monitoring metrics must support tracking enrollment and ex parte renewals. The state must describe successes and challenges related to activities to annually update beneficiary contact information, provide beneficiaries reminders of continued eligibility, verify beneficiary residency, and confirm that the beneficiary is not deceased, for all beneficiaries who qualify for a continuous eligibility period that exceeds 12 months.

3. Evaluation of the Demonstration

3.1 Evaluation Questions and Hypotheses:

For the continuous eligibility policy, the state must evaluate the impact of the policy on all relevant populations, appropriately tailored for the specific time span of eligibility. Evaluation hypotheses must focus on, but may not be limited to, enrollment continuity, utilization of age-appropriate preventive care, inpatient admissions and avoidable emergency care, and health disparities.

4. General Financial Requirements

4.1 Medicaid Expenditure Groups. Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 2: Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
CE – Children	**Hypo**	X		X	All expenditures for continued benefits for children who have been determined eligible for the continuous eligibility period who would otherwise lose coverage during an eligibility determination.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

4.2 Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS 11-W-00114/2. For the CE MEG, 2.6 percent for adults or 0.11 percent for children of expenditures are allocated to the CE MEG. Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by Demonstration Year (DY) according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable

calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Member Months. As part of the Quarterly and Annual Monitoring Reports, the state must report the actual number of "eligible member months" and expenditures for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below, with the exception of the Continuous Eligibility (CE) MEGs. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.
   For CE MEGs, states will report a calculated number, or percentage, of the actual member months and expenditures of the corresponding non-CE MEG. As applicable, the corresponding non-CE MEG member months and expenditures will then be reduced by the same percentage. For the Children CE MEGs, this percentage will be 0.11 percent. For example, the actual member months and expenditures for children up to age six in the TANF Child MEG will be reduced by .11 percent and the equivalent member months and expenditures will be reported on the CE Children MEG so that the total calculated member months and expenditures between the two MEGs are equal to the actual member months and expenditures for the TANF Child group.

b. Budget Neutrality Specifications Manual**.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual or calculated expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 3: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	CMS-64.9 or 64.10 Line(s) to Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
CE - Children	Children who are eligible via CE, equaling 0.11% of total Medicaid expenditures for Children 0-6	Follow 64.9 Base Category of Service Definition	Date of service	MAP	Y 0.11% of total member months for children aged 0-6	11/14/2024	03/31/2027

4.3 Budget Neutrality Monitoring Tool: The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in Section 5. CMS will provide technical assistance, upon request.[1]

5. Monitoring Budget for the Demonstration

5.1 Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual or calculated number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of Federal Financial Participation (FFP) that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

5.2 Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them

[1] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual or calculated costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

5.3 Hypothetical Budget Neutrality Test 4: Continuous Eligibility: The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditure in excess of the limit from Hypothetical Budget Neutrality Test 4 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 4: Hypothetical Budget Neutrality Test 4

MEG	PC or AGG	WOW Only, WW Only, or Both	Base Year DY21	Trend Rate	DY 24	DY 25	DY 26	DY 27	DY 28
CE - Children	PC	Both	$274.63	2.8%	$0	$0	$315.29	$324.12	$333.20

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

6. Monitoring Allotment Neutrality

6.1 Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement. The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

a. Tracking Expenditures: In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 and CMS 64 reporting instructions as outlined in section 2115 of the State Medicaid Manual.

b. Use of Waiver Forms: Title XXI demonstration expenditures will be reported on the following separate forms designated for Medicaid-expansion CHIP (M-CHIP) (i.e., Forms 64.21U Waiver and/or CMS-64.21UP Waiver) and S-CHIP (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments

were made). The state must submit separate CMS-21 and CMS-64.21U waiver forms for each title XXI demonstration population.

c. Claiming Period: All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the CMS-21 and CMS-64.21U waiver forms, net expenditures related to dates of service during the operation of the demonstration.

6.2 Standard CHIP Funding Process. The standard CHIP funding process will be used during the demonstration. The state will continue to estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for S-CHIP and CMS-37 for M-CHIP. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the S-CHIP population and report demonstration expenditures for the M-CHIP population through Form 64.21U Waiver and/or CMS-64.21UP Waiver. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver and the CMS 64.21U Waiver/CMS-64.21UP Waiver forms with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

6.3 Title XXI Administrative Costs. Administrative costs will not be included in the allotment neutrality limit. All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.

6.4 Limit on Title XXI Funding. New York will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 1.2 during the demonstration period. Federal title XXI funds for the state's CHIP program are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Expenditures only allowable through the demonstration are limited to remaining title XXI funds.

6.5 Exhaustion of Title XXI Funds for S-CHIP Population. If the state exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the state must continue to provide coverage to the approved title XXI separate state plan population.

6.6 Exhaustion of Title XXI Funds for M-CHIP Population. If the state has exhausted title XXI funds, expenditures for this population as approved within the CHIP state plan, may be claimed as title XIX expenditures, as approved in the Medicaid state plan. The state must notify CMS in writing at least 90 days prior to an expected change in claiming of expenditures for the M-CHIP population. The state shall report demonstration expenditures for these individuals, identified as "M-CHIP," on the Forms CMS 64.9W and/or CMS 64.9P W.