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State/Territory Name: New York

State Plan Amendment (SPA) #: NY-17-0023-CA

This file contains the following documents in the order listed:

The complete title XXI state plan for New York consists of the most recent state plan posted on Medicaid.gov under CHIP and State Plan Amendments. The link is provided below. The following approved templates are in addition to, or replace sections of the state's posted current state plan. The attached approval letter(s) explain how these templates fit into that state plan.

Link to state title XXI state plans and amendments: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-State-Program-Information.html

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

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

Children and Adults Health Programs Group

NOV 17 2017

Judith Arnold, Director
Division of Coverage & Enrollment
Office of Health Insurance Programs
State of New York Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237-0004

Dear Ms. Arnold:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) NY-16-0023-CA has been approved. This SPA describes New York's policy to provide retroactive coverage for newborns if the application is received within 60 days after birth, and implements two CHIP Health Services Initiatives (HSI) by providing funding to: 1) support the training of school officials and staff to administer naloxone rescue kits to reverse opioid overdoses, and 2) support the provision of emergency meals and nutrition education to low-income children and their families. The SPA has an effective date of January 1, 2017 for the retroactive coverage of newborns and April 1, 2016 for each of the HSIs.

SPA NY-16-0023-CA is a revision of NY-16-0023-CHIP that was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 31, 2017. The original SPA submission, NY-16-0023-CHIP, also included a proposed HSI to support local health departments' lead poisoning and prevention activities. New York separated the proposed retroactive newborn coverage policy and HSIs (now SPA NY-17-0023-CA) from the lead poisoning and prevention HSI (now SPA NY-17-0023-CB). The state provided additional information about NY-17-0023-CA on October 24, 2017. SPA NY-17-0023-CB remains off the clock pending additional information from the state.

Section 2105(a)(1)(D)(ii) of the Social Security Act (the Act) and 42 CFR §457.10 authorize use of title XXI administrative funding for expenditures for HSIs under the plan for improving the health of children, including targeted low-income children and other low-income children. Consistent with section 2105(c)(6)(B) of the Act and 42 CFR §457.626, title XXI funds used to support an HSI cannot supplant Medicaid or other sources of federal funding.

The state shall ensure that the remaining title XXI funding, within the state's 10 percent limit, is sufficient to continue the proper administration of the CHIP program. If such funds become less than sufficient, the state agrees to redirect title XXI funds from the support of these HSIs to the administration of the CHIP program.

Your title XXI project officer is Ms. Kristin Edwards. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Edwards' contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-5480
E-mail: kristin.edwards@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Edwards and to Mr. Michael Melendez, Associate Regional Administrator (ARA) in our New York Regional Office. Mr. Melendez's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3811
New York, NY 10278-0063

If you have additional questions, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721.

We look forward to continuing to work with you and your staff.

Sincerely,

/ Anne Marie Costello /

Anne Marie Costello
Director

Enclosure

cc: Mr. Michael Melendez, ARA, Region II

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 State
(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/ Judith Arnold March 31, 2017
(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: Judith Arnold	Position/Title: CHIP Director Director, Division of Eligibility and Marketplace Integration
Name: Gabrielle Armenia	Position/Title: Director, Bureau of Child Health Plus Policy and Exchange Consumer Assistance
Name:	Position/Title:

***Disclosure. 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 0938-0707. The time required to complete this information collection 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. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA 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 105-33 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 of 2010 further modified the program.

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:

- o 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.
- o 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)
- o Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- o Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a 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 a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
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)); (42CFR, 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 XXIXIX.

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
Effective Date:

Implementation Date:

SPA #___, Purpose of SPA_____
Proposed effective date:

Proposed implementation date:

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-16-0022- C – B

Submission date:	March 28, 2016
Effective date (HSI Medical Indemnity Fund):	April 1, 2015
Implementation date:	April 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

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	Eligibility – Targeted Low Income Children	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3
		CS15	MAGI-Based Income Methodologies	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	Residency	Supersedes the current section 4.1.5
		CS18	Citizenship	Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR
		CS19	Social Security Number	Supersedes the current section 4.1.9.1
		CS20	Substitution of Coverage	Supersedes the current section 4.4.4
		CS21	Non-Payment of Premiums	Supersedes the current section 8.7
	General Eligibility	CS27	Continuous Eligibility	Supersedes the current section 4.1.8
		CS28	Presumptive Eligibility for Children	Supersedes the current section 4.3.2

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.

TN No: Approval Date Effective Date _____

Section 2. **General Background and Description of Approach to Children's Health Insurance Coverage and Coordination**

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

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

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

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

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

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

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

1. Opioid Drug Addiction and Opioid Overdose Prevention Program for Schools

Program Details

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

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

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

Program funding is used to train individuals throughout the State as opioid overdose responders. The public health law was expanded in an amendment effective August 11, 2015 to specifically include school districts, boards of cooperative educational services, county vocational education and extension boards, charter schools and nonpublic elementary and/or secondary schools, as well as persons employed by these districts, boards or schools. As such, they are expressly authorized to respond to opioid overdoses through the administration of naloxone. Over 265 programs have registered with the Department, and approximately 100,000 overdose responders have been trained to date.

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

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

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

Budget and HSI Claiming Details

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

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

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

Periodic general ledger journal entries will be processed to move the qualified expenditures to CHIP federal funding. The expenses will be transferred from each fund source according to its percentage of the total funding. These transactions will be performed in the Statewide Financial System (SFS) and are approved within the Department, and at the Office of the State Comptroller (OSC). Backup documentation will be included when the journal entries are processed. There is distinct coding in SFS for the opioid program funding, and for CHIP funding. There is also a specific program code for CHIP HSI expenditures, to distinguish them from other CHIP expenditures.

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

2. Hunger Prevention Nutrition Assistance Program (HPNAP)

Program Details

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

HPNAP funding supports 46 Department contracts, which includes eight regional food banks and 38 direct service providers statewide. Through these contracts, approximately 240 million emergency meals are provided each year throughout the State. HPNAP works with an established network of more than 2,500 Emergency Food Programs (EFP, including food banks, food pantries and soup kitchens, to leverage private and public partnerships.

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

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

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

HPNAP maximizes service levels by utilizing the cost efficient emergency food relief network, and by closely monitoring contractor performance. All contractors receiving HPNAP funding must complete timely, accurate reports of monthly service levels, as specified in the HPNAP contract. In addition, HPNAP contract managers perform site visits for each of the program's 46 contractors each year.

Budget and HSI Claiming Details

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

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

The contracts associated with these programs use the State funded appropriation referenced above, but also a receive a small amount of federal funding through Nutrition-related grants. However, these federal funds are an allocation and not a match. For the purpose of the HSI, the federal funding allocation will be excluded and only the State funds will be considered.

Periodic general ledger journal entries will be processed to move the qualified expenditures to CHIP federal funding. These transactions will be performed in SFS, and are approved within the Department, and at OSC. Backup documentation will be included when the journal entries are processed. There is distinct coding in SFS for HPNAP funding, and for CHIP funding. There is also a specific program code for CHIP HSI expenditures, to distinguish them from other CHIP expenditures.

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

Assurances

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

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

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

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

Section 4. Eligibility Standards and Methodology

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. ☒ **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group:

Children ages 6-18 from 100 to 133 percent of the Federal Poverty Level

4.1. ☒ **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0 ☒ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

In accordance with Section 211 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), New York State enacted legislation effective October 1, 2010 adding a new eligibility requirement that children applying for Child Health Plus coverage who declare to be a United States citizen produce satisfactory documentary evidence of their citizenship status and identity. New York State has implemented the data file match process afforded under CHIPRA to comply with this requirement. Applying children who do not provide their Social Security Number and those children whose citizenship cannot be successfully verified by the Social Security Administration must supply documentation of United States citizenship and identity.

☐ **4.1.1** Geographic area served by the Plan if less than Statewide:

☒ **4.1.2** Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

4.1.2.1-PC ☒ Age: Less than 19 years of age under 400 percent of the federal poverty level.

4.1.3 ☒ Income of each separate eligibility group (if applicable):

4.1.3.1-PC ☒ 0% of the FPL (and not eligible for Medicaid) through 400% of the FPL (SHO #02-004, issued November 12, 2002)

Effective September 1, 2008, a child residing in a household having a gross household income at or below 400 percent of the federal poverty level (as defined and annually revised by the federal Office of Management and Budget) is eligible for Child Health Plus.

☐ **4.1.4** Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

☒ **4.1.5** Residency (so long as residency requirement is not based on length of time in state):

A child must be a resident of New York State.

☐ **4.1.6** Disability Status (so long as any standard relating to disability status does not restrict eligibility):

☒ **4.1.7** Access to or coverage under other health coverage:

Child must not be eligible for Medicaid, have other insurance coverage unless the policy is one of the "Excepted Benefits" set forth in federal Public Health Service Act (accident only coverage or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including auto insurance; worker's compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; dental only, vision only, or long term care insurance; specified disease coverage; hospital indemnity or other fixed dollar indemnity coverage; or CHAMPUS/Tricare supplemental coverage) or have a parent or guardian who is a public employee of the State or public agency with access to family health insurance coverage by a state health benefits plan where the public agency pays all or part of the cost of the family health insurance coverage.

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, an 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 access to the New York State Health Insurance Program or has obtained other health insurance coverage; has become enrolled in Medicaid; has reached the age of 19; or the applicable premium payment has not been paid. 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 New York State of Health (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.

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.

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 New York State of Health if that is where enrollment originated. If enrollment originated with the health plan prior to January 1, 2014, changes must be reported directly to the health plan. 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 enrolled in Medicaid based on the new information.

4.1.9 ☒ Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 ☒ States should specify whether Social Security Numbers (SSN) are required.

New York requires that an applicant provide their social security number if they have one. Applicants who are unable to obtain a social security number due to their immigration status or because of religious objections may still apply for and be eligible for coverage.

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 access to the New York State Health Insurance Program or has obtained other health insurance coverage; the child has enrolled in Medicaid; the child has reached the age of 19; or the applicable premium payment has not been paid. 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.

4. **1-PW** ☐ **Pregnant Women Option** (section 2112) The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1) "lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR ☒ **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);

(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:

(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);

(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101649, as amended;
(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
(vi) Aliens currently in deferred action status; or
(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women.
☒ Elected for children under age 19.

4.1.1-LR ☒ The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4. **1-DS** ☐ **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2. Assurances The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

☐ **4.2.1.** These standards do not discriminate on the basis of ☐ diagnosis.

4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. ☐ These standards do not deny eligibility based on a child having a preexisting medical condition. This applies to pregnant women as well as targeted low-income children.

2-DS Supplemental Dental - Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1-DS ☐ These standards do not discriminate on the basis of diagnosis.

4.2.2-DS ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3-DS ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. **Methodology.** Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

Children must recertify annually. At the State's discretion, additional time may be allowed for enrollees to complete the renewal process 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.

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.2.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR, 457.305(b))

☒ Check here if this section does not apply to your State.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.2.2. ☒ Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

A two- month presumptive period of eligibility is available to children as a means of providing services under the Child Health Plus program when a child appears eligible for the program but pertinent documentation is missing. Effective January 1, 2014, if one or more pieces of required documentation such as income or immigration status is missing but the applicant appears eligible based on the application submitted to NY State of Health, the family is allowed up to two months to submit the documentation or the child is disenrolled from the program. At the State's discretion, additional time may be allowed for enrollees to supply required documentation to fully enroll the child 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.

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3. 3-EL Express Lane Eligibility ☐ Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances.
(Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4. Eligibility screening and coordination with other health coverage programs
States must describe how they will assure that:

4.4.1. ☒ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.

Effective January 1, 2014, New York State of Health application asks if the child has any other health insurance or Medicaid. If the child indicates he/she has other coverage, the application further asks for specific detail to determine if it is one of the excepted benefits as stated in 4.1.7. If it is not, the child is determined ineligible for Child Health Plus coverage. As a further check, prior to enrollment, a check is performed to ensure the child does not have Medicaid or other public coverage. If this results in a match, the child is not enrolled in Child Health Plus.

4.4.2. ☒ children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102(b)(3)(B)) (42CFR, 457.350(a)(2))

Effective January 1, 2014, New York State of Health, New York's Health Insurance Marketplace, is an integrated eligibility system that determines eligibility for Child Health Plus, Medicaid and Qualified Health Plans, with and without tax credits. The applicant applies for financial assistance, not a specific program. If, based on eligibility factors, the child is determined Medicaid eligible, he/she will be enrolled in Medicaid and not Child Health Plus.

4.4.3. ☒ children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

Effective January 1, 2014, New York State of Health, New York's Health Insurance Marketplace, is an integrated eligibility system that determines eligibility for Child Health Plus, Medicaid and Qualified Health Plans, with and without tax credits. The applicant applies for financial assistance, not a specific program. If, based on eligibility factors, the child is determined Child Health Plus eligible, he/she will be enrolled in Child Health Plus, not Medicaid.

4.4.4. ☒ the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)

The State monitors prior insurance of applicants to ensure that the program does not substitute for coverage under group health plans. The application on New York State of Health asks if the applicant currently has insurance or if they have had coverage within the past 90 days. If they currently have health coverage, they are not eligible for the program. If they had health coverage, they are questioned if it was through their employer and the reason they no longer have health insurance through their employer. For children under 250 percent of the federal poverty level, the State collects the information on prior health insurance status quarterly from the health plans. This information is analyzed to determine the percentage of new enrollees who have dropped employer-based health insurance for

enrollment in CHPlus. If the percentage reaches an average of eight (8) percent for the last three (3) quarters, a six-month waiting period will be imposed. The responsible adult filling out an application must attest to the source and nature of any health care coverage the child is receiving or has received in the past six months.

Children whose gross family income is between 251% and 400% of the federal poverty level (as defined and updated by the United States Department of Health and Human Services) cannot have had a private employer-based health insurance coverage during the past six months unless such coverage was dropped due to the following:

(a) Loss of employment due to factors other than voluntary separation;
(b) Death of the family member which results in termination of coverage under a group health plan under which the child is covered;
(c) Change to a new employer that does not provide an option for comprehensive health benefits coverage;
(d) Change of residence so that no employer-based comprehensive health benefits coverage is available;
(e) Discontinuation of comprehensive health benefits coverage to all employees of the applicant's employer;
(f) Expiration of the coverage periods established by COBRA or the provisions of subsection (m) of section three thousand two hundred twenty-one, subsection (k) of section four thousand three hundred four and subsection (e) of section four thousand three hundred five of the insurance law;
(g) Termination of comprehensive health benefits coverage due to long term disability;
(h) The cost of employment based health insurance is more than 5 percent of the family's income;
(i) A child applying for coverage under these provisions is pregnant;
(j) A child applying for coverage under this provision is at or below the age of five;
(k) Child has special health care needs;
(l) Child lost coverage as a result of a divorce; or
(m) The cost of family coverage including the child exceeds 9.5% of household income.

The Department will monitor the number of children who are subject to the waiting period.

4.4.4.1. ☐ (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))

4.4.5. ☒ Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102(b)(3)(D)) (42 CFR 457.125(a))

Through statewide CHPlus and Medicaid coverage, the provision of health insurance to targeted low-income children in the State who are Indians as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c) is ensured. The Department also maintains an Indian Health Program which deals directly with the Native American populations on or near all reservations in the State. All health care providers who deal with the Native American population encourage enrollment in CHPlus. The referral process to CHPlus is included in the contracts between the Department and reservation health care providers.

To further enhance outreach and potential enrollment of Native Americans, several IPA/Navigator grantees provide application assistance to tribes throughout the State. ~~This includes a grant with the American Indian Community House.~~

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

☐ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

☐ The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

☐ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

CHIP Budget – Part A (HPNAP and Opioid Programs)

STATE: New York	**FFY Budget 2015-16 Actuals**	**FFY Budget 2016-17 Projected**	**FFY Budget 2017-18 Projected**
State's enhanced FMAP rate	**88%**	**88%**	**88%**
Benefit Costs			
Insurance payments	$729,108,770	$758,273,120	$781,021,314
Managed care	$504,883,426	$525,078,763	$540,831,126
per member/per month rate			
Fee for Service			
Total Benefit Costs	**$1,233,992,196**	**$1,283,351,883**	**$1,321,852,440**
(Offsetting beneficiary cost sharing payments)	($56,800,000)	($56,800,000)	($56,800,000)
Net Benefit Costs	**$1,177,192,196**	**$1,226,551,883**	**$1,265,052,440**
Cost of Proposed SPA Changes – Benefit			
Administration Costs			
General administration	$19,000,000	$25,000,000	$25,000,000
Contractors/Brokers			
Claims Processing			
Outreach/marketing costs		$100,000	$100,000
Health Services Initiatives – 1		$1,250,000	$1,250,000
Health Services Initiatives – 2		$0	$9,050,000
Other			
Total Administration Costs	**$19,000,000**	**$26,350,000**	**$35,400,000**
10% Administrative Cost Ceiling	$130,799,132	$136,283,543	$140,561,382
Federal Share	$1,052,649,133	$1,102,553,657	$1,144,398,147
State Share	$143,543,064	$150,348,226	$156,052,293
Total Costs of Approved CHIP Plan	**$1,196,192,196**	**$1,252,901,883**	**$1,300,452,440**

Section 6.

Note:

The Health Services Initiative – 1 line includes projections for Sickle Cell and Poison Control, which were approved in SPA NY-16-0022-C-A. The Health Services Initiatives – 2 line shows projections for HPNAP and Opioid programs, which are being submitted in this SPA.