TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: New York
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b)) /s/ Gabrielle Armenia June, 2020
(Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Name: _____	Position/Title: _____
Name: _____	Position/Title: _____
Name: _____	Position/Title: _____

*Disclosure. In accordance with the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). 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 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

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

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

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

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

review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

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

The template includes the following sections:

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

must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

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

eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

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

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

  Medicaid Expansion- CHIP SPA Requirements
  In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:
  - 1 (General Description)
  - 2 (General Background)

  They will also be required to complete the appropriate program sections, including:
  - 4 (Eligibility Standards and Methodology)
  - 5 (Outreach)
  - 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
  - 10 (Annual Reports and Evaluations).

  Medicaid Expansion- Medicaid SPA Requirements
  States expanding through Medicaid-only will also be required to submit a Medicaid State plan amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:
  - 3 (Methods of Delivery and Utilization Controls)
  - 4 (Eligibility Standards and Methodology)
  - 6 (Coverage Requirements for Children's Health Insurance)
  - 7 (Quality and Appropriateness of Care)
  - 8 (Cost Sharing and Payment)
  - 11 (Program Integrity)
  - 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes

of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The

implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan

Original Submission

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

SPA #1

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

SPA #2

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

SPA #3

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

SPA #4

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

SPA #5 (compliance)

Submission date:	March 31, 2003

SPA #6 (renewal process)

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

SPA #7

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

SPA #8

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

SPA #9

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

SPA # 10

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

SPA # 11

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

SPA # 12

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

SPA # 13

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

SPA # 14

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

SPA # 15

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

SPA # 16

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

SPA # 17

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

SPA # 18

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

SPA # 19

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

SPA # 20

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

SPA #21

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

SPA #NY-16-0022- C-A

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

SPA #NY-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

SPA #NY – 19-0024

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

SPA #NY- 20-0026

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

SPA #NY- 20-0027

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

SPA #NY- 20-0028

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

SPA #NY- 20-0029

Submission Date:	June, 2020
Effective Date: (HSI Newborn Screening and Early Intervention Programs) Provisions	April 1, 2020
Implementation Date:	April 1, 2020

Superseding Pages of MAGI CHIP State Plan Material

State: New York

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
NY-14-0001 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS15	Eligibility – Targeted Low-Income Children MAGI-Based Income Methodologies	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Incorporate within a separate subsection under section 4.3
NY-14-0002 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
NY-14-0003 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
NY-13-0004 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
NY-14-0005 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility General Eligibility	CS17 CS18 CS19 CS20 CS21 CS27 CS28	Residency Citizenship Social Security Number Substitution of Coverage Non-Payment of Premiums Continuous Eligibility	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR Supersedes the current section 4.1.9.1 Supersedes the current section 4.4.4 Supersedes the current section 8.7 Supersedes the current section 4.1.8 Supersedes the current section 4.3.2

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
			Presumptive Eligibility for Children	
NY-19-0025 Effective/Implementation Date: April 1, 2018	Non-Financial Eligibility	CS20	Substitution of Coverage	Supersedes the previously approved CS20.

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Consistent with New York's approved tribal consultation policy, a letter was mailed to all federally recognized tribes in New York State on _____ notifying them of the proposed State Plan Amendment. A link was provided in the letter for purposes of allowing the tribes to view the proposed State Plan Amendment. The tribes were given two weeks to provide comments/feedback on the proposed State Plan Amendment. No feedback was received within the prescribed timeframe.

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. NEWBORN SCREENING PROGRAM

Program Details

Description

The Newborn Screening Program ("program") is mandated under New York State Public Health Law, sections 2500-a and 2500-f. The program is administered by the Wadsworth Center for Laboratories and Research within the New York State Department of Health ("Department"). The program tests and identifies infants with serious but treatable neonatal conditions and refers those infants for immediate medical intervention. State law requires all infants born in the state to be tested unless parents confirm, in writing, that they have a religious objection.

The program is crucial as failure to complete testing protocols accurately and timely can result in catastrophic health consequences, including death, for affected infants. The program's goal is to help affected newborns live as long and normal a life as possible. Early recognition and treatment of most disorders leads to a better outcome for the newborn. Most newborns will not have a disorder. However, even an infant that appears healthy could have a disorder.

New York's Newborn Screening Program was established in 1965. The program is one of the most expansive in the United States, with approximately 270,000 specimens from 250,000 infants tested each year. A daily average of more than 1,000 specimens must be tested. The laboratory reports in excess of 13 million test results annually. Since the program's inception, millions of infants have been tested and thousands have been identified and treated for their diseases.

Screening Process

Around 24 to 36 hours after birth, hospital personnel collect a blood sample from the newbom. The sample arrives at the Wadsworth Center, the state's public health laboratory, within 48 hours of collection. At the laboratory, the specimen is screened for about 50 congenital conditions. All test results are reported to the newborn's birth hospital and primary care doctor. The parents obtain the results from the doctor. Federal recommendations state that critical results must be available within five days and all test results must be available within seven days. Screening is designed to identify all newborns with the potential for the disorders. Further testing may be required to verify whether the newborn has the disorder.

Overview

Staff and related costs account for approximately half of the program's disbursements. Staff is responsible for the actual testing of all newborn screening specimens in the state, evaluation activities, and various other functions. Laboratory supplies and equipment, including their maintenance, represent the balance of program spending.

Program Evaluation

The Recommended Uniform Screening Panel (RUSP) is a list of disorders that the Secretary of the Department of Health and Human Services recommends for states to test for as part of their newborn screening programs. New York's testing panel is compliant with RUSP and the program maintains compliance by adding new conditions when they are added to the RUSP.

The program regularly evaluates new technology to improve the performance of screening for conditions on the current panel and for future addition to the panel. It performs reviews of medical significance and checks the availability of appropriate testing technologies and treatment protocols. The reviews are conducted on a continuing basis to ensure newborns are screened for an appropriate panel. The program also conducts quality assurance and quality control activities on a mandated schedule.

The program continually manages quality assurance to ensure that all clinical testing procedures always maintain peak performance. The program participates in quarterly evaluation challenges from the federal Centers for Disease Control and Prevention's Newborn Screening Quality Assurance Program. The New York State Clinical Laboratory Evaluation Program (CLEP) reviews all state clinical testing for proper validation. CLEP conducts routine inspections/audits to ensure that all standard operating procedures are in place and all clinical aspects of the program are compliant with the state's public health law. Additionally, the federal Clinical Laboratory Improvement Amendments Program performs routine inspections/audits of the program.

Staff Functions

Aside from actual specimen testing and program evaluation activities, staff members answer questions concerning testing; educate hospital staff in collecting suitable specimens; conduct training sessions; and prepare and distribute various educational materials, including videos,

posters and brochures. The program gives feedback to birth hospitals on performance measures including the rate of unsuitable specimens and the time it takes for specimens to reach the laboratory.

The program reminds providers of their open cases and makes scheduled inquiries so that outstanding diagnoses can be provided, and cases closed. A designated unit ascertains the ongoing health status of infants identified by the screening program to ensure they are under appropriate medical care and have a clinical diagnosis. The program works closely with health care providers to assure newborns with abnormal test results receive appropriate confirmatory diagnoses and treatment.

Laboratory Supplies and Equipment

Screening tests require a high level of rapidly evolving technology. As new technology becomes available, existing technology is discontinued and is no longer supported for instrument and/or software maintenance. This requires the program to purchase new instrumentation and technology upgrades. In addition, the critical and time-sensitive nature of the work compels the program to maintain essential maintenance contracts. As advances are made in treatment for genetic diseases, the number of recommended conditions is expected to increase. Accordingly, new conditions will be added to the testing panel to ensure newborns in New York are receiving the same level of care as those in other states. The program must also purchase chemicals and supplies for daily testing and initial and ongoing technical validation.

Budget Details

Disbursements: Staff and Related Costs

During state fiscal year (SFY) 2019-20, which runs April 1, 2019 through March 31, 2020, total program disbursements totaled $13.13 million. Approximately half (52 percent), or $6.80 million, of total program disbursements were attributed to staffing (personal service) and its associated fringe benefits and indirect costs. As of the two-week pay period ending March 4, 2020, the program's staff consisted of 46 full-time equivalents: (1) laboratory administrator, (1) laboratory specialist, (4) office assistants, (3) public health representatives, and (37) research scientists.

Disbursements: Non-Personal Service

Non-personal service totaled $6.32 million during SFY 2019-20, or approximately 48 percent of overall program disbursements. About 94 percent of non-personal service disbursements were for laboratory supplies and equipment and their maintenance. The remainder of non-personal service disbursements included shipping (4 percent), administrative costs (1 percent), and other various costs.

Appropriations

The program's appropriations are located on pages 297 and 298 in New York State's SFY 2020-21 Enacted Budget for State Operations. The appropriations are within the Department of Financial

Services' (DFS) section of the budget bill. The funding source is the Insurance Department Account, which is one of the state's miscellaneous special revenue funds.

The appropriations total $13.38 million for SFY 2020-21. There are appropriations for personal service, various non-personal service, fringe benefits and indirect costs. DFS sub-allocates (transfers) the appropriations to the Department by the processing of interunit budget transfers in New York's Statewide Financial System (SFS). The program will continue to use this funding for payment of its expenditures in the first instance.

General Ledger Journal Entries

With approval of this state plan amendment, general ledger journal entries will be processed in SFS to transfer eligible Newborn Screening Program disbursements to CHIP federal funding. The Bureau of Budget Management (BBM) within the Department will initiate the general ledger journal entries in SFS. These transactions require a second level of approval within the Department and approval by the Office of the New York State Comptroller. BBM will attach appropriate backup documentation to the transactions. There are distinct program codes for the Newborn Screening Program and CHIP, and there is a unique sub-program code within CHIP dedicated to health services initiatives. The applicable CHIP federal match for the quarter in which the original Newborn Screening disbursement occurred will be used for the general ledger journal entries and for the claiming of these expenditures in the CMS-21 report.

Percentage Related to Children

As the program is related to the screening of newborns, the entire population served is children under 18. Therefore, all Newborn Screening disbursements will be considered as related to children under 18. Total program disbursements for a given period will be multiplied by the applicable CHIP federal matching rate to determine the amount eligible to be transferred to CHIP federal funding.

2. EARLY INTERVENTION PROGRAM

Program Details

Description

The New York State Early Intervention Program ("program") is part of the national Early Intervention Program for infants and toddlers with disabilities and their families. It was created by Congress in 1986 under the Individuals with Disabilities Education Act (IDEA). In New York, the program was established in Article 25 of the Public Health Law and has been in effect since July 1, 1993. The New York State Department of Health ("Department") is designated as the lead agency for the state and is responsible for general administration, supervision and oversight of the program. The program is managed within the Department by the Bureau of Early Intervention.

The mission of the program is to identify and evaluate as early as possible those infants and toddlers whose healthy development is compromised and provide for appropriate intervention to improve the family and child's development. The program is family-centered and supports parents in meeting their responsibility to nurture and enhance their child's development. The program serves approximately 70,000 children. The Department enters into agreements with providers who deliver the program's services. There are about 1,300 providers under agreement, with approximately 18,000 qualified personnel rendering services to children and their families.

Eligibility

To be eligible for services, a child must be under three years of age and have a confirmed disability or established developmental delay. A disability means that a child has a diagnosed physical or mental condition that may lead to developmental problems. These include, but are not limited to, autism, Down syndrome, motor disorders, or vision and hearing problems. A developmental delay signifies that a child is behind in some area of development, such as growth, learning and thinking, or communicating.

Services

The program offers a variety of therapeutic and support services to eligible infants and toddlers with disabilities and their families, including: family education and counseling; home visits; parent support groups; special instruction; speech pathology and audiology; occupational therapy; physical therapy; psychological services; service coordination; nursing services; nutrition services; social work services; vision services; and assistive technology devices and services. These services help the family learn the best ways to care for the infant/toddler, support and promote the child's development, and include the child in family and community activities.

The program is community-based. It creates opportunities for full participation of children with disabilities and their families in their communities by ensuring services are delivered in natural environments to the maximum extent appropriate. The services are provided anywhere in the community where the child typically spends their day, including the home; the child-care center or family day care home; community/recreational centers, play groups, playgrounds, libraries, or

any place parents and young children go for fun and support; and early childhood programs and centers, such as Early Head Start.

Process

The program is administered locally by 57 counties and New York City. Each locality has an Intervention Official and a designated office responsible for administration and oversight of the program. Referral to the local office is the first step of the process. Parents may refer their own child if they have a concern about their child's development. In New York, certain professionals are also required to refer children to the program if a developmental problem is suspected.

After referral, the infant/toddler is evaluated by qualified professionals. If the child is eligible, the local program assists the parents in obtaining services. A specially designed written plan is developed for each child in the program. The plan outlines and explains the services the child and family will receive. An ongoing service coordinator is assigned to each case and facilitates and monitors the process. A transition plan is developed for the child as they approach their third birthday.

Budget Details

Funding Sources and Payment Details for Services

The program's services are provided at no cost to the parents. Services are financed through a combination of state funding, local funding and third-party payers (commercial insurance and Medicaid). Pursuant to state Public Health Law, billing providers must seek payment in the first instance from third-party payers to the extent that a child has private insurance regulated by the state or is enrolled in Medicaid. While services are funded from multiple sources, only the state funding will be considered for this health services initiative.

Providers submit claims for services rendered via the New York Early Intervention System (NYEIS) or through a secure portal supported by the program's state fiscal agent (SFA), the Public Consulting Group. The SFA submits the provider claims to applicable third-party payers and generates standardized municipal voucher for the services that are not covered by third-party payers. The local offices make payment for costs not covered by the third-party payers. The state reimburses the local offices a portion of their costs through voucher payments in SFS.

Department and Local Office Administration

State funding supports contracts with the local offices for payment of local administration of the program. In addition, federal Department of Education funding contributes to local administration and the Department's administration of the program. However, no administration payments will be considered for this Health Services Initiative.

Disbursements

Total program disbursements are projected at approximately $165.0 million per year. Historically, payments to local offices for reimbursement of program services have accounted for approximately 98 percent of total program spending. The remaining 2 percent has funded contracts with the local offices for their administration of the program. The administration payments are excluded from this Health Services Initiative.

Appropriation

The program's state funding appropriation is located on page 747 in New York State's SFY 2020-21 Enacted Budget for State Operations. The appropriation totals $165.0 million. The appropriation is in Center for Community Health Program major program within the Department's section of the budget bill. The funding source is the General Fund, Local Assistance account. The General Fund is the state's main operating fund.

General Ledger Journal Entries

With approval of this state plan amendment, general ledger journal entries will be processed in SFS to transfer eligible state funding Early Intervention Program disbursements to CHIP federal funding. The Bureau of Budget Management (BBM) within the Department will initiate the general ledger journal entries in SFS. These transactions require a second level of approval within the Department and approval by the Office of the New York State Comptroller. BBM will attach appropriate backup documentation to the transactions. There are distinct program codes for the Early Intervention Program and CHIP, and there is a unique sub-program code within CHIP dedicated to health services initiatives. There are sub-program codes within Early Intervention to distinguish between services and administration expenditures. The applicable CHIP federal match rate for the quarter in which the original Early Intervention Program disbursement occurred will be used for the general ledger journal entries and for the claiming of these expenditures in the CMS-21 report.

Percentage Related to Children

As program eligibility is limited to individuals under age three, the entire population served is children under 18. Therefore, all Early Intervention disbursements will be considered related to children under 18. Total state funding program disbursements for a given period will be multiplied by the applicable CHIP federal matching rate to determine the amount eligible to be transferred to CHIP federal funding.

ASSURANCES

New York assures that the two proposed health services initiatives 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 the all (100 percent) of the funds transferred (state and federal) are retained by the Newborn Screening Program and the Early Intervention Program.

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.

CHIP Budget

STATE: New York	2019	2020	2021
Benefit Costs			
Insurance payments	$787,880,600	$939,700,290	$1,041,800,000
Managed Care	$814,632,300	$853,745,000	$890,000,000
Fee for Service			
Total Benefit Costs	$1,602,512,900	$1,793,445,290	$1,931,800,000
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	$1,602,512,900	$1,793,445,290	$1,931,800,000
Administration Costs			
Personnel			
General Administration	$40,664,434	$41,884,367	$41,501,578
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs	$2,355,002	$2,425,652	$2,498,422
Other (e.g., indirect costs)			
Health Services Initiatives (Approved)	$10,059,179	$10,360,954	$11,172,000
Health Services Initiatives (Proposed)	$0	$89,064,500	$159,472,444
Health Services Initiatives (Total)	$10,059,179	$99,425,454	$170,644,444
Total Administration Costs	$53,078,615	$143,735,473	$214,644,444
10% Administrative Cap (net benefit costs/9)	$178,056,989	$199,271,699	$214,644,444
Federal Title XXI Share	$1,456,920,533	$1,481,943,284	$1,395,188,889
State Share	$198,670,982	$455,237,479	$751,255,556
TOTAL COSTS OF APPROVED CHIP PLAN	$1,655,591,515	$1,937,180,763	$2,146,444,444