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 March 7, 2023
(Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

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

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

Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

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

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved Section s 2.2 and 2.3 into Section 5 to eliminate redundancies between Section s 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 Section s:

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. (Section s 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 Section s:

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

They will also be required to complete the appropriate program Section s, 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 Section s are incorporated by reference through their State Medicaid plans for Section s:

- 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 (Section s 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 Section s 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

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

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

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has

increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

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

Original Plan

Original Submission

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

SPA #1

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

SPA #2

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

SPA #3

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

SPA #4

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

SPA #5 (compliance)

Submission date:	March 31, 2003

SPA #6 (renewal process)

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

SPA #7

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

SPA #8

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

SPA #9

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

SPA # 10

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

SPA # 11

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

SPA # 12

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

SPA # 13

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

SPA # 14

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

SPA # 15

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

SPA # 16

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

SPA # 17

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

SPA # 18

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

SPA # 19

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

SPA # 20

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

SPA #21

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

SPA #NY-16-0022- C-A

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

SPA #NY-17-0023 – C - A

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

SPA #NY – 19-0024

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

SPA # NY -19-0025

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

SPA #NY- 20-0026– *Pending Approval*

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

SPA #NY- 20-0027– *Pending Approval*

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

SPA #NY- 20-0028

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

SPA #NY- 20-0029

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

SPA #NY- 21-0030 – *Pending Approval*

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

SPA #NY- 21-0031-CHIP

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

SPA #NY- 21-0032-CHIP

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

SPA #NY-22-0033-CHIP

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

SPA #NY-23-0034-CHIP

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

SPA #NY-23-0034A-CHIP

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

Superseding Pages of MAGI CHIP State Plan Material

State: New York

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

		CS28	Presumptive Eligibility for Children	Supersedes 4.3.2
NY-19-0025 Effective/Implementation Date: April 1, 2018	Non-Financial Eligibility	CS20	Substitution of Coverage	Supersedes the previously approved CS20.
NY-23-0034A-CHIP Effective/Implementation Date: April 1, 2022	Eligibility	CS9	Coverage From Conception to Birth	

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.

A letter was mailed to all federally recognized tribes in New York State on February 17, 2023 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.

Section 3. Methods of Delivery and Utilization Controls

☒ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 4 (Eligibility Standards and Methodology).

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by

population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

Under the CHPlus program, the Department contracts with health plans for the purchase of a managed care insurance product. Health plans are paid a per member per month (PMPM) fee for a uniform benefit package that is comparable to the Medicaid managed care package.
Costs for vaccines are excluded from the PMPM fee and are purchased by the New York State Department of Health and distributed, for CHPlus enrollees, by the New York State and New York City Departments of Health through their Vaccine for Children programs. [and distributed, for CHPlus enrollees, by the NY State Department of Health through its Vaccine for Children program.] Children, through the managed care arrangement, have primary care providers who coordinate their health care, including referrals to specialists, when appropriate. Insurers participate in the program as a result of a competitive RFP process. However, those health plans that are approved New York State Medicaid Managed Care insurers are allowed to participate in the CHPlus program without a competitive bid or request for proposal process. These insurers are authorized to contract with the State to provide a CHPlus managed care product. Health plans are in every geographic region of the State, assuring statewide coverage. Health plans are monitored for the provision of health care services through the semi and annual reporting of the services provided and through the reporting of data through the quality assurance and reporting system.

3.1. Delivery Systems (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)

3.1.1 Choice of Delivery System

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

☐ No, the State does not use a managed care delivery system for any CHIP populations.

☐ Yes, the State uses a managed care delivery system for all CHIP populations.

☒ Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations,

please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

Effective April 1, 2022, New York added prenatal coverage from conception to the end of pregnancy (FCEP) for uninsured pregnant consumers with income from 0 to 218% FPL, plus 5% deduction, who are not otherwise eligible for Medicaid or CHIP. The FCEP population will receive services through Medicaid managed care. Only emergency and non-emergency medical transportation services are delivered through fee-for service.

3.1.1.2 Do any of your CHIP populations that receive services through a managed care delivery system receive any services outside of a managed care delivery system?

☐ No
☒ Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others.

Emergency medical transportation and non-emergency medical transportation services are carved out of the managed care delivery system and are provided through fee-for service.

3.1.2 Use of a Managed Care Delivery System for All or Some of the State's CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

☒ Managed care organization (MCO) (42 CFR 457.10)
- ☐ Capitation payment
  Describe population served: pregnant individuals residing in a household having a household income at or below 223% FPL who choose to seek pregnancy-related health care services and who otherwise meets the eligibility criteria.

☐ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)

☒ Capitation payment
☐ Other (please explain)
Describe population served:

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:

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.

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:

See SPA CS9 pages for age standards under the CHIP State Plan.

Effective April 1, 2022, New York's separate CHIP program covers targeted low-income children from conception to the end of pregnancy (FCEP) for uninsured pregnant consumers with income from 0 to 218% FPL, plus 5% deduction, not otherwise eligible for Medicaid or CHIP.

4.1.2.1-PC ☒ Age: conception through birth (SHO #02-004, issued November 12, 2002)

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

See CS9 pages for income standards under the CHIP State Plan.

4.1.3.1-PC ☒ 0% of the FPL (and not eligible for Medicaid) through 218%, plus 5% deduction of the FPL (SHO #02-004, issued November 12, 2002)

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):

Eligible persons 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:

Effective April 1, 2022, New York provides coverage from conception to the end of pregnancy (FCEP) for uninsured pregnant consumers with income up to and including 218% FPL, plus 5% deduction, not otherwise eligible for Medicaid or CHIP. In determining household size, the "unborn child" or "children" will be counted as if born and living with the pregnant parent.

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.

See CS9 attachment, this population is exempt from requirement of providing or applying for a Social Security Number.

Section 6. Coverage Requirements for Children's Health Insurance

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,

- surgical and medical services,
- laboratory and x-ray services,
- well-baby and well-child care, including age-appropriate immunizations, and
- emergency services;

- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,
  - mental health services,
  - vision services and
  - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. **(**Section 2103(a)(2))

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to

time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

6.1.3. ☒ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

6.1.4. ☐ Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

6.1.4.1. ☐ Coverage of all benefits that are provided to children under the the same as Medicaid State plan, including Early Periodic Screening Diagnosis and Treatment (EPSDT)

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver

6.1.4.3. ☐ Coverage that the State has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in 457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☒ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

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

6.1.4.7. ☒ Other (Describe)

Coverage for the FCEP Population:

Effective April 1, 2022, New York provides coverage from conception to the end of pregnancy (FCEP) for uninsured pregnant consumers in households with income up to 218% FPL, plus 5% deduction, not otherwise eligible for

Medicaid or CHIP.

Pregnant persons who are receiving services through the FCEP population shall continue to be eligible to receive services through the end of the month in which the 60th postpartum day occurs, regardless of any subsequent changes in household income.

Through New York's Medicaid and CHIP managed care organizations (MCOs), New York utilizes bundled capitated payment arrangements for coverage of services including prenatal, labor and delivery, and postpartum services.

New York considers all services delivered to the pregnant persons through managed care during the pregnancy through 60 days postpartum to support the health from conception to the end of pregnancy (FCEP) who at birth may be eligible as a targeted low-income child. New York claims CHIP federal financial participation (FFP) under this State Plan for managed care costs for the covered population through 60 days postpartum.

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

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

The coverage provided to the FCEP will be the same as that provided under the State's Medicaid program, which reflects the Medicaid state plan covered benefits for pregnant individuals. As described in the following attachments:

Attachment 3.1-A
https://www.hcrapools.org/medicaid_state_plan/Attachment_PDF_PROD/attach_3-1a.pdf

Attachment 3.1-A Supplement
https://www.hcrapools.org/medicaid_state_plan/Attachment_PDF_PROD/attach_3-1a_supp.pdf

Attachment 3.1-A Supplement 1
https://www.hcrapools.org/medicaid_state_plan/Attachment_PDF_PROD/attach_3-1a_supp1.pdf

Attachment 3.1-B
https://www.hcrapools.org/medicaid_state_plan/Attachment_PDF_PROD/attach_3-1b.pdf

Attachment 3.1-B Supplement
https://www.hcrapools.org/medicaid_state_plan/Attachment_PDF_PROD/attach_3-1b_supp.pdf

Attachment 3.1-H
https://www.hcrapools.org/medicaid_state_plan/Attachment_PDF_PROD/attach_3-1h.pdf

6.2.1.A ☒ Inpatient services (Section 2110(a)(1))

6.2.2.A ☒ Outpatient services (Section 2110(a)(2))

6.2.3.A ☒ Physician services (Section 211A0(a)(3))

6.2.4.A ☒ Surgical services (Section 2110(a)(4))

6.2.5.A ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

6.2.6.A ☒ Prescription drugs (Section 2110(a)(6))

6.2.7.A ☒ Over-the-counter medications (Section 2110(a)(7))

6.2.8.A ☒ Laboratory and radiological services (Section 2110(a)(8))

6.2.9. A ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

6.2.10.A ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

6.2.11.A ☒ Disposable medical supplies (Section 2110(a)(13))

Section 12., Page 33 of Attachment 3.1-A Supplement

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with

activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

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

Guidance Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.13.A ☒ Nursing care services (Section 2110(a)(15))

6.2.14.A ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)

6.2.15.A ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

6.2.16.A ☒ Vision screenings and services (Section 2110(a)(24))

6.2.17.A ☒ Hearing screenings and services (Section 2110(a)(24))

6.2.18.A ☒ Case management services (Section 2110(a)(20))

6.2.19.A ☒ Care coordination services (Section 2110(a)(21))

6.2.20.A ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

6.2.21.A ☒ Hospice care (Section 2110(a)(23))

Guidance: See guidance for Section 6.1.4.1 for a guidance on the statutory requirements for EPSDT under Section s 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check this box.

6.2.22.A ☐ EPSDT consistent with requirements of Section s 1905(r) and 1902(a)(43) of the Act

6.2.22.1A ☐ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Section s 6.2 and 6.3- BH of the CHIP state plan

can be exceeded as medically necessary.

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.23.A ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

6.2.24.A ☒ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.25.A ☒ Medical transportation (Section 2110(a)(26))

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.26.A ☒ Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

6.2.27.A ☐ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

Section 8. Cost-Sharing and Payment

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☒ Yes
8.1.2. ☐ No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

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

8.2.1. ☒ Premiums:

<223% FPL $0 $0
223%-250%* $15 $45
251%-300% $30 $90
301%-350%* $45 $135
351%-400% $60 $180

*American Indians/Native Americans exempt from Family contribution At the State's discretion, non-payment of premiums may be temporarily forgiven/waived or families may be given additional time to pay their premiums for CHIP applicants and/or existing beneficiaries who reside and/or work in a State or federally declared disaster area.

* No cost-sharing imposed on the FCEP population.

8.2.2. ☐ Deductibles:

8.2.3. ☐ Coinsurance or copayments:

8.2.4. ☐ Other:

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5)

(42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

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

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
  - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

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

- Total 1-year cost of adding prenatal coverage
- Estimate of unborn children covered in year 1

CHILD HEALTH PLUS BUDGET SUMMARY

	Actual	*Projected*	*Projected*
Benefit Costs	**2021-22**	**2022-23**	**2023-24**
Insurance Payments	$911,643,937	$993,527,223	$1,060,339,961
Managed Care Payments	$926,033,582	$967,705,093	$1,011,251,822
Fee for Service			
Total Benefit Costs	$1,837,677,518	$1,961,232,316	$2,071,591,783
(Offsetting beneficiary cost sharing payments)	($60,553,536)	($44,112,000)	($44,112,000)
Net Benefit Costs	$1,777,123,982	$1,917,120,316	$2,027,479,783
FCEP Cost	$0	$164,357,345	$281,755,448
Net Benefit Costs Plus FCEP Cost	$1,777,123,982	$2,081,477,661	$2,309,235,231
Administration Costs	**2021-22 Actual**	**2022-23 Projected**	**2023-24 Projected**
Personnel	$1,724,444	$1,776,177	$1,829,462
General Administration	$38,098,163	$87,134,436	$87,516,607
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs	$4,161,331	$4,286,171	$4,414,756
Other (e.g., indirect costs)	$1,164,616	$1,199,555	$1,235,541
Health Services Initiatives	$152,309,667	$156,878,957	$161,585,326
Total Administration Costs	$197,458,220	$231,275,296	$256,581,692
10% Administrative Cap	$197,458,220	$231,275,296	$256,581,692
Federal Title XXI Share	$1,369,175,299	$1,583,831,043	$1,674,516,270
State Share	$605,406,903	$728,921,913	$891,300,654
TOTAL COSTS OF APPROVED CHIP PLAN	$1,974,582,203	$2,312,752,956	$2,565,816,923