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State/Territory Name: **New York**

State Plan Amendment (SPA) #: **24-0034**

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

May 1, 2024

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza Rm. 1605
Albany, NY 12237

Re: New York State Plan Amendment (SPA) 24-0034

Dear Medicaid Director Bassiri:

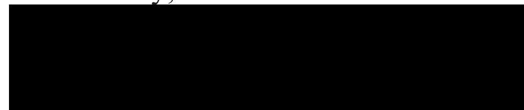
The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) NY-24-0034. This amendment proposes to technically correct the plan to add back approved language erroneously dropped from the approved SPA 19-0003 and carried forward to approved SPA 22-0043.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act. This letter informs you that New York's Medicaid SPA TN 24-0034 was approved on May 1, 2024, with an effective date of January 1, 2024.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the New York State Plan.

If you have any questions, please contact Melvina Harrison at 212-616-2247 or via email at Melvina.Harrison@cms.hhs.gov.

Sincerely,



James G. Scott, Director
Division of Program Operations

Enclosures

cc: Regina Deyette

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 2 4 — 0 0 3 4

2. STATE: N Y

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT ◉ XIX ○ XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION: § 1905(a)(6) Medical Care, or Any Other Type of Remedial Care

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 01/01/24-09/30/24 $ 0
b. FFY 10/01/24-09/30/25 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-B: Page 3
Attachment 3. 1-A: Page 3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-B: Page 3
Attachment 3. 1-A: Page 3

9. SUBJECT OF AMENDMENT
Technical Correction to 19-0003 and 22-0043

10. GOVERNOR'S REVIEW *(Check One)*
◉ GOVERNOR'S OFFICE REPORTED NO COMMENT
○ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
○ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
○ OTHER, AS SPECIFIED:

11. [redacted] OFFICIAL

12. TYPED NAME: Amir Bassiri

13. TITLE: Medicaid Director

14. DATE SUBMITTED: March 29, 2024

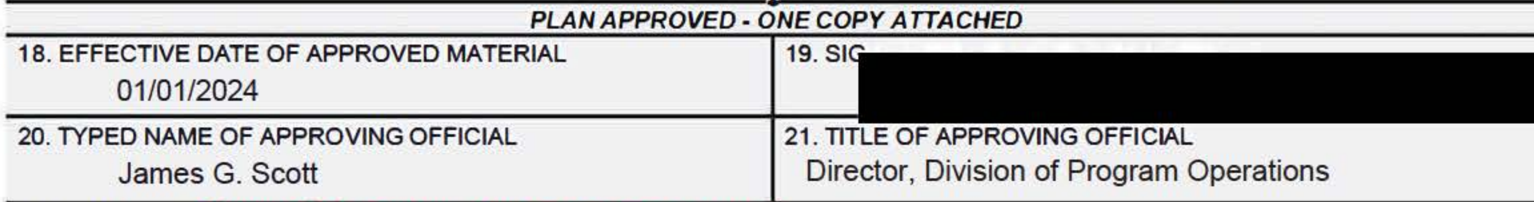
15. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR CMS USE ONLY

16. DATE RECEIVED: 03/29/2024

17. DATE APPROVED: **05/01/2024**

PLAN APPROVED - ONE COPY ATTACHED



18. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/2024

19. SIG[redacted]

20. TYPED NAME OF APPROVING OFFICIAL: James G. Scott

21. TITLE OF APPROVING OFFICIAL: Director, Division of Program Operations

22. REMARKS Pen and ink changes: State authorized on 4/25/24.

Box 7: Page Number of the Plan Section or Attachment:
Attachment 3. 1-A: Page 3
Attachment 3. 1-B: Page 3

Box 8: Page Number of the Superceded Plan Section or Attachment
Attachment 3. 1-A: Page 3
Attachment 3. 1-B: Page 3

New York
3

1905(a)(6) Medical Care, Or Any Other Type Of Remedial Care

**AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

b. Optometrists' services.

[X] Provided: [ ] No limitations [X] With limitations *

c. Chiropractors' services. (EPSDT only.)

[X] Provided: [ ] No limitations [X] With limitations *

[ ] Not Provided.

d. Other practitioners' services.

[X] Provided: Identified on attached sheet with description of limitations, if any.

[ ] Not Provided.

(i). Other Licensed Practitioner services. (EPSDT only.)
[X] Provided: Identified on attached sheet with description of limitations, if any.
[ ] Not Provided.

(ii). Licensed Clinical Social Worker (LCSW)
[X] Provided: Identified on attached sheet with description of limitations, if any.
[ ] Not Provided.

(iii). Licensed Mental Health Counselor (LMHC) and Licensed Marriage and Family Therapists (LMHT)
[X] Provided: Identified on attached sheet with description of limitations, if any.
[ ] Not Provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: [ ] No limitations [X] With limitations *

b. Home health aide services provided by a home health agency.

Provided: [ ] No limitations [X] With limitations *

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: [ ] No limitations [X] With limitations *

* Description provided on attachment.

State/Territory: New York

AMOUNT DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): _________

1905(a)(6) Medical Care, Or Any Other Type Of Remedial Care

6. **Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practices as defined by State law.**

   a. **Podiatrists' Services**
   [X] Provided: [ ] No limitations [X] With limitations*

   b. **Optometrists' Services**
   [X] Provided: [ ] No limitations [X] With limitations*

   c. **Chiropractors' Services**
   [X] Provided: [ ] No limitations [X] With limitations*
   [ ] Not Provided.

   d. **Other Practitioners' Services**
   [X] Provided: Identified on attached sheet with description of limitations, if any.
   [ ] Not Provided.

   (i.) Other Licensed Practitioner Services (EPSDT only)
   [X] Provided: Identified on attached sheet with description of limitations, if any.
   [ ] Not Provided.

   (ii). Licensed Clinical Social Worker (LCSW)
   [X] Provided: Identified on attached sheet with description of limitations, if any.
   [ ] Not Provided.

   (iii). Licensed Mental Health Counselor (LMHC) and Licensed Marriage and Family Therapists (LMHT)
   [X] Provided: Identified on attached sheet with description of limitations, if any.
   [ ] Not Provided.

7. **Home Health Services**

   a. **Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.**
   [X] Provided: [ ] No limitations [X] With limitations*

   b. **Home health aide services provided by a home health agency.**
   [X] Provided: [ ] No limitations [X] With limitations*

   c. **Medical supplies, equipment, and appliances suitable for use in the home.**
   [X] Provided: [ ] No limitations [X] With limitations*

   d. **Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or social rehabilitation facility.**
   [ ] Provided [X] No limitations [ ] With limitations

*Description provided on attachment.