

## **Table of Contents**

**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

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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:

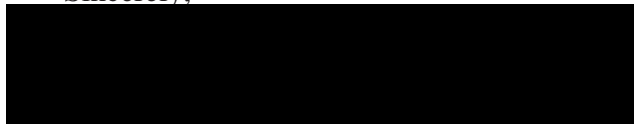
The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) NY-24-0034. This amendment proposes to technically correct the plan to add back approved language erroneously dropped from the approved SPA 19-0003 and carried 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](mailto:Melvina.Harrison@cms.hhs.gov).

Sincerely,



James G. Scott, Director  
Division of Program Operations

Enclosures

cc: Regina Deyette

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER <u>2</u> <u>4</u> — <u>0</u> <u>0</u> <u>3</u> <u>4</u>	2. STATE <u>NY</u>
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	

TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE <b>January 1, 2024</b>
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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 <u>01/01/24-09/30/24</u> \$ <u>0</u> b. FFY <u>10/01/24-09/30/25</u> \$ <u>0</u>
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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
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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, ASSPECIFIED:

11. NY OFFICIAL [REDACTED]	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
12. TYPED NAME Amir Bassiri	
13. TITLE Medicaid Director	
14. DATE SUBMITTED March 29, 2024	

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	[REDACTED]
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20. TYPED NAME OF APPROVING OFFICIAL James G. Scott	21. TITLE OF APPROVING OFFICIAL Director, Division of Program Operations
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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 Superseded Plan Section or Attachment:  
Attachment 3.1-A: Page 3  
Attachment 3.1-B: Page 3

New York  
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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.

Provided:             No limitations             With limitations \*

c. Chiropractors' services. (EPSDT only.)

Provided:             No limitations             With limitations \*

Not Provided.

d. Other practitioners' services.

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

Not Provided.

(i). Other Licensed Practitioner services. (EPSDT only.)

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

Not Provided.

(ii). Licensed Clinical Social Worker (LCSW)

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)

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             With limitations \*

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

Provided:             No limitations             With limitations \*

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

Provided:             No limitations             With limitations \*

\* Description provided on attachment.

TN           #24-0034          

Supersedes TN           #22-0043          

Approval Date:           05/01/2024          

Effective Date:           January 1, 2024

## New York

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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.

TN       #24-0034      Approval Date:       05/01/20024      Supersedes TN       #22-0043      Effective Date:       January 1, 2024