



Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

March 29, 2024

James G. Scott, Director
Division of Program Operations
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

RE: SPA #24-0034
Non-Institutional Services

Dear Mr. Scott:

The State requests approval of the enclosed amendment #24-0034 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 1, 2024 (Appendix I). This amendment is being submitted to make a technical correction to previously approved SPAs 19-0003 and 22-0043. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by § 1902(a)(30) of the Social Security Act and 42 CFR § 447.204.

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

**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

NY

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

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

Attachment 3.1-B: 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. SIGNATURE OF STATE AGENCY OFFICIAL

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

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Appendix I
2024 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

New York

3

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 _____

Supersedes TN #22-0043Effective Date January 1, 2024

Appendix II
2024 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #24-0034

This State Plan 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.