

**STATE PLAN UNDER TITLE XIX  
OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
Medical Assistance Program

New York  
i

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**LIST OF ATTACHMENTS**

<u>No.</u>	<u>Title of Attachment</u>
*1.1-A	Attorney General's Certification
*1.1-B	Waivers under the Intergovernmental Corporation Act
1.2-A	Organization and Function of State Agency
1.2-B	Organization and Function of Medical Assistance Unit
1.2-C	Professional Medical and Supporting Staff
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	* Supplement 1 - Reasonable Classifications of Individuals under the Age of 21, 20, 19 and 18
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	* Supplement 1 - Income Eligibility Levels – Categorically Needy, Medically Needy and Qualified Medicare Beneficiaries
	* Supplement 2 - Resource Levels – Categorically Needy, Including Groups with Incomes Up to a Percentage of the Federal Poverty Level, Medically Needy, and Other Optional Groups
	* Supplement 3 - Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
	* Supplement 4 - Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program

\* Forms Provided

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**No.**

**Title of Attachment**

- \* Supplement 5 - Section 1902(f) Methodologies for Treatment of Resources that Differ from those of the SSI Program
- \* Supplement 5a - Methodologies for Treatment of Resources for Individuals With Incomes Up to a Percentage of the Federal Poverty Level
- \* Supplement 6 - Standards for Optional State Supplementary Payments
- \* Supplement 7 - Income Levels for 1902(f) States – Categorically Needy Who Are Covered under Requirements More Restrictive than SSI
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- \* Supplement 8a - More Liberal Methods of Treating Income Under Section 1902(r)(2) of the Act
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- \* Supplement 9 - Transfer of Resources
- \* Supplement 10 - Consideration of Medicaid Qualifying Trusts – Undue Hardship
- \* Supplement 11 - Cost-Effective Methods for COBRA Groups (States and Territories)

\*2.6-A

Eligibility Conditions and Requirements (Territories only)

- \* Supplement 1 - Income Eligibility Levels – Categorically Needy, Medically Needy, and Qualified Medicare Beneficiaries
- \* Supplement 2 - Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
- \* Supplement 3 - Resource Levels for Optional Groups with Income Up to a Percentage of the Federal Poverty Level and Medically Needy
- \* Supplement 4 - Consideration of Medicaid Qualifying Trusts – Undue Hardship
- \* Supplement 5 - More Liberal Methods of Treating Income under Section 1902(r)(2) of the Act
- \* Supplement 6 - More Liberal Methods of Treating Resources under Section 1902(r)(2) of the Act

\* Forms Provided

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**New York**  
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<b><u>No.</u></b>	<b><u>Title of Attachment</u></b>
*3.1-A	Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy <ul style="list-style-type: none"> <li>* Supplement 1 - Case Management Services</li> <li>* Supplement 2 - Alternative Health Care Plans for Families Covered Under Section 1925 of the Act</li> </ul>
*3.1-B	Amount, Duration, and Scope of Services Provided Medically Needy Groups
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4.19-A	Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care
* Forms Provided	

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**4**

<u>No.</u>	<u>Title of Attachment</u>
4.19-B	Methods and Standards for Establishing Payment Rates – Other Types of Care  * Supplement 1 - Methods and Standards for Establishing Payment Rates for Title XVIII Deductible/Coinsurance
4.19-C	Payments for Reserved Beds
4.19-D	Methods and Standards for Establishing Payments Rates – Skilled Nursing and Intermediate Care Facility Services
4.19-E	Timely-Claims Payment – Definition of Claim
4.20-A	Conditions for Direct Payment for Physicians' and Dentists' Services
4.22-A	Requirements for Third Party Liability – Identifying Liable Resources
*4.22-B	Requirements for Third Party Liability – Payment of Claims
*4.22-C	Cost-Effective Methods for Employer-Based Group Health Plans
*4.32-A	Income and Eligibility Verification System Procedures: Requests to Other State Agencies
*4.33-A	Method for Issuance of Medicaid Eligibility Cards to Homeless Individuals
7.2-A	Methods of Administration – Civil Rights (Title VI)
* Forms Provided	

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*NOTE: Page deleted under approved SPA 13-0056-MM4*  
*Approved Date: 10/24/2014 Effective Date: 01/01/2014*  
*Refer to Attachment 1.1-A (PDF A1) Section*

**[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM]**

**[Citation**

45 CFR  
Part 201  
AT-76-141

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the

New York State Department of Health  
(single state agency)

submits the following State plan for the medical assistance program , and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.]

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New York  
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**Refer to Attachment 1.1-A (PDF A1) Section**

**[SECTION 1 SINGLE STATE AGENCY ORGANIZATION**

**Citation**  
42 CFR 431.10  
AT-79-29

**1.1 Designation and Authority**

- (a) The New York State Department of Health is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to “the Medicaid agency” mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.]

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**Refer to Attachment 1.1-A (PDF A1) Section**

[Citation  
Section 1902(a)  
of the Act

1.1(b) The State agency that administered or supervised the administration of the plan approved under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

[X] Yes. The State Agency so Designated is:  
Commission for the Blind and  
Visually Handicapped.

This agency has a separate plan covering that portion of the State Plan under Title XIX for which it is responsible.

[ ] Not applicable. The entire plan under Title XIX is administered or supervised by State agency named in paragraph 1.1(a).]

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**Refer to Attachment 1.1-A (PDF A1) Section**

[Citation  
Intergovernmental  
Cooperation Act  
Of 1968

1.1(c) Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

Not applicable. Waivers are no longer in effect.

Not applicable. No waivers have ever been granted.]

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**Refer to Attachment 1.1-A (PDF A1) Section**

**[Citation]**  
42 CFR 431.10  
AT-79-29

- [X] The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this Plan.
  
- [ ] Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in Attachment 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.]

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**Refer to Attachment 1.1-A (PDF A1) Section**

[Citation  
42 CFR 431.10  
AT-79-29

- 1.1(e) All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.
- (f) All other requirements of 42 CFR 431.10 are met.]

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**Refer to Attachment 1.1-A (PDF A1) Section**

[Citation  
42 CFR 431.11  
AT-79-29

**1.2 Organization for Administration**

- (a) Attachment 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.
- (b) Within the State agency, the Office of Medicaid Management has been designated As the medical assistance unit. Attachment 1.2-B contains a description of the organization and functions of the medical assistance unit and an organizational chart of the unit.
- (c) Attachment 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.
- (d) Eligibility determinations are made by the State or local staff of an agency other than the agency named in paragraph 1.1(a). Attachment 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

[x] Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determinations.]

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**Refer to Attachment 1.1-A (PDF A1) Section**

[Citation]	Condition or Requirement
<b>Citation</b> 42 CFR 431.50 (b) AT-79-29	<b>1.3 Statewide Operation</b>  The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.  <input checked="" type="checkbox"/> The plan is State administered.  <input checked="" type="checkbox"/> The plan is administered by the political subdivisions of the State and is mandatory on them.]

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New York  
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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**Tribal Consultation Requirements**

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)(I) 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.

Please 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. Please include information about the frequency, inclusiveness and process for seeking such advice.

Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

**Tribal Consultation Process**

For changes to the State's Medicaid Plan (Plan) that require a State Plan Amendment (SPA), Indian nation leaders and health clinic administrators and Urban Indian Organization leaders and health department administrators will be sent a letter altering that a new tribal consultation has been posted. This notification will be accompanied by summaries of each proposed amendment, an offer of availability of State staff to meet with respective Indian leaders in person upon request made within two weeks of the date of the notification, and also a weblink to the Department of Health website where you may also view the draft plan pages and Federal Public Notice for each proposal. Tribal consultations will be sent at least two weeks prior to submitting a SPA to CMS for approval, allowing for a two-week comment period. [copy of the Federal Public Notice related to a particular SPA, along with a cover letter offering the availability of State staff to meet with respective Indian leaders in person upon requests made within two weeks of the date of notification. A least two weeks' prior to submitting a SPA to CMS for approval, a draft copy of the proposed amendment will be forwarded to the above Indian representatives, allowing for a two-week comment period.] Indian health clinic administrators will be notified via e-mail, and all other Indian representatives will be notified via U.S. Postal Service.

TN #17-0065

Approval Date 03/12/2018

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New York  
9-1

For Medicaid policy changes that do not require a SPA, a draft copy of the Administrative Directive related to the change will be forwarded to Indian representatives, as outlined above, for a two-week comment period. A State contact person will be identified for each draft directive.

Written notification of the State's intent to submit proposals for demonstration projects or new applications, amendments, extension requests or renewals for waivers that have an impact on Indians, Indian health providers or Urban Indian Organizations will be made to Indian representatives, as identified above, at least 60 days prior to the publication and submission of such. Indian health clinic administrators will be notified via e-mail, and all other Indian representatives will be notified via U.S. Postal Service.

**Tribal Consultation Process Development**

State representatives attended the 2011 Department of Health and Human Services (HHS) Annual Regional Tribal Consultation Session held on March 29, 2011. At that meeting, State staff distributed and discussed the draft Federal Public Notice which contained a summary description of the proposed tribal consultation policy. State staff also distributed a draft SPA and conducted a PowerPoint presentation, both of which elaborated on the proposed tribal consultation policy. Tribal representatives received contact information for various State staff who could answer any questions that may arise. As of May 1, 2011, no questions or comments were received by the State subsequent to the above meeting.

In addition, copies of all handouts were left with HHS IHS representatives to share with those Indian nations and Urban Indian Organizations who did not have representatives in attendance. Further, on April 29, 2011, the State mailed a package to Indian nation and organization leaders and Indian health clinic administrators, which discussed the March 29, 2011 presentation, included the handouts from the presentation, and offered a two-week period of time in which to comment or request a personal meeting with State staff. No responses to our mailing were received as of May 13, 2011.

TN #11-06

Supersedes TN NEW

Approval Date August 4, 2011

Effective Date April 1, 2011

New York

9a

Citation

1928 of the Act

1.5 Pediatric Immunization Program

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.
  - a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.
  - b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.
  - c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.
  - d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.
  - e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.
  - f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.
  - g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

TN #94-33

Supersedes TN #NEW

Approval Date August 18, 1994

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**Attachment 1.1**

**New York  
9b**

**Citation**

1928 of the Act

2. The State has not modified or repealed any Immunization law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.
3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.
4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

  X   State Medicaid Agency

  X   State Public Health Agency

TN   #97-10  

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New York  
10

*This page has been superseded by PDF S94 of the MAGI Eligibility SPAs, effective 10/1/13.*

[SECTION 2 - COVERAGE AND ELIGIBILITY]

[Citation  
42 CFR  
435.10 and  
Subpart J]

[2.1 Application, Determination of Eligibility and  
Furnishing Medicaid

- (a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.]

TN #13-54

Approval Date March 13, 2014

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Effective Date October 1, 2013

New York  
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**Citation**

42 CFR  
435.914  
1902(a)(34)  
of the Act

2.1(b)(1) Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in [ATTACHMENT 2.6-A](#).

1902(e)(8) and  
1905(a) of the  
Act

(2) For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. [ATTACHMENT 2.6-A](#) specifies the requirements for determination of eligibility for this group.

1902(a)(47) and  
1920 of the Act

X (3) Pregnant women are entitle to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. [ATTACHMENT 2.6-A](#) specifies the requirements for determination of eligibility for this group.

42 CFR  
434.20

(c) The Medicaid agency elects to enter into a risk contract with an HMO that is—

X Qualified under title XIII of the Public Health Service Act or is provisionally qualified as an HMO pursuant to section 1903(m)(3) of the Social Security Act.

X Not Federally qualified, but meets the requirements of 42 CFR 434.20(c) and is defined in [ATTACHMENT 2.1-A](#).

\_\_\_ Not applicable.

TN #93-27

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New York  
11a

*This page has been superseded by PDF S94 of the MAGI Eligibility SPAs, effective 10/1/13.*

**[Citation**

1902(a) (55)  
of the Act]

[2.1(d) The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a) (10) (A) (i) (IV), (a) (10) (A) (i) (VI), (a) (10) (A) (i) (VII), and (a) (10) (A) (ii) (IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.]

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**New York  
11b**

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
SECTION 2 – COVERAGE AND ELIGIBILITY**

**Citation(s)**

**2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)**

1902(e)(13) of  
the Act

(e) Express Lane Option. The Medicaid State agency elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of Medicaid eligibility. The Medicaid State agency agrees to meet all of the Federal statutory and regulatory requirements for this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after 9/30/2017.

(1) The Express Lane option is applied to:

Initial determinations                       Redeterminations  
 Both

(2) A child is defined as younger than age:

19                                               20                                               21

(3) The following public agencies are approved by the Medicaid State agency as Express Lane agencies:

[The New York State Department of Health (NYSDOH), Office of Health Insurance Program (OHIP), [Division of Coverage and Enrollment (DCE)] Division of Eligibility and Marketplace Integrations (DEMI) administers the Medicaid and Child Health Plus (CHPlus, New York's separate CHIP program) programs. At CHPlus redetermination, the Medicaid agency elects to rely on findings from the Child Health Plus program to determine initial eligibility for the Medicaid program.

When applying or renewing for Temporary Assistance the Medicaid agency elects to rely on findings from Temporary Assistance program to automatically enroll and renew eligible children in Medicaid.]

TN #17-0066

Approval Date March 8, 2018

Supersedes TN #15-0003

Effective Date October 1, 2017

New York  
11c

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)

- (4) The following component/components of Medicaid eligibility are determined under the Express Lane option. Also, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between Medicaid eligibility determinations for such children and the determination under the Express Lane option.

[Child Health Plus annually renews eligibility for children enrolled in CHPlus. Under the screen and enroll process, the first step is to determine if the child is eligible for Medicaid. In order to streamline eligibility for children who screen Medicaid eligible, the Department of Health is implementing a process that will send the eligibility findings made at the renewal by CHPlus to the Local Departments of Social Services (LDSS).

The State will use an income finding from CHPlus and apply this income information to enroll a child in Medicaid if a child is found to be ineligible for CHPlus at renewal. Both Medicaid and Child Health Plus use MAGI (modified adjusted gross income) to determine eligibility. Medicaid will be accepting the income findings determined by CHPlus using MAGI methodology based on Medicaid income rules.

Medicaid and CHPlus both use the same residency rules. Neither Medicaid nor CHPlus require documentation of residency at renewal. Medicaid will accept the CHPlus agency's finding for residency.

Temporary Assistance requires the same verification of citizenship that Medicaid requires for eligibility. Income budgeting is slightly different, Temporary Assistance uses net income after allowing income disregards. Medicaid determines eligibility using MAGI (modified adjusted gross income) methodology. Since TA income guidelines are lower than the Medicaid levels, this slight discrepancy in budgeting income would not affect eligibility in a majority of the cases.]

TN   #17-0066  

Approval Date   March 8, 2018  

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Effective Date   October 1, 2017

**New York  
11d**

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
SECTION 2 – COVERAGE AND ELIGIBILITY**

Citation(s)

**2.1 Application, Determination of Eligibility and Furnishing  
Medicaid (Continued)**

(5) Check off which option is used to satisfy the Screen and Enroll requirement before a child may be enrolled under Title XXI.

(a) Screening threshold established by the Medicaid agency as:

(i) \_\_\_ percentage of the Federal Poverty Level (FPL) which exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points: specify \_\_\_\_\_; or

(ii) \_\_\_ percentage of the FPL (describe how this reflects the value of any differences between income methodologies of Medicaid and the Express Lane agency; or

(b) Temporary enrollment pending screen and enroll.

(c) State's regular screen and enroll process for CHIP.

[If Medicaid eligible based on the findings of the Express Lane Agency, the child is given two months of temporary CHPlus coverage, and the case information will be sent to LDSS to open a Medicaid case. In upstate counties, this process will be done manually and in NYC, this will be done electronically.

In both upstate counties and NYC, when a child is determined eligible for Temporary Assistance, the child will automatically be given Medicaid with no action required by the family.]

(6) The State elects the option for automatic enrollment without a Medicaid application, based on data obtained from other sources and with the child's or family's affirmative consent to the child's Medicaid enrollment.

(7) The State elects the option to rely on a finding from an Express Lane agency that includes gross income or adjusted gross income shown by State income tax records or returns.

TN #17-0066  
Supersedes TN #15-0003

Approval Date March 8, 2018  
Effective Date October 1, 2017

New York  
12

**Citation**

42 CFR  
435.10

**2.2 Coverage and Conditions of Eligibility**

Medicaid is available to the groups specified in [ATTACHMENT 2.2-A](#).

- Mandatory categorically needy and other required special groups only.
- Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.
- Mandatory categorically needy, other required special groups, and specified optional groups.
- Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in [ATTACHMENT 2.6-A](#).

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

TN #91-76

Supersedes TN #87-35A

Approval Date March 3, 1992

Effective Date October 1, 1991

New York  
13

**NOTE: The deleted information on this page has been replaced by  
PDFs S88 effective January 1, 2014.**

[State: New York]

<u>[Citation(s)]</u>	<u>[Groups Covered]</u>
<p><b><u>[Citation]</u></b> 435.10 and 435.403, and 1902(b) of the Act, P.L. 99-272 (Section 9529) And P.L. 99-509 (Section 9405)]</p>	<p><b><u>[2.3 Residence]</u></b>  Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.]</p>

TN #13-57

Approval Date March 26, 1990

Supersedes TN #87-35A

Effective Date July 1, 1987

New York  
14

**Citation**

42 CFR 435.530(b)  
42 CFR 435.531  
AT-78-90  
AT-79-29

**2.4 Blindness**

All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in [ATTACHMENT 2.2-A](#).

TN #87-35A

Supersedes TN #76-22

Approval Date March 26, 1990

Effective Date July 1, 1987

New York  
15

**Citation**

42 CFR  
435.121,  
435.540(b)  
435.541

**2.5 Disability**

All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.14.b. of [ATTACHMENT 2.2-A](#) of this plan.

TN #91-76

Supersedes TN #87-35A

Approval Date March 3, 1992

Effective Date October 1, 1991

New York  
16-17

**Citation(s)**

42 CFR  
435.10 and  
Subparts G & H  
1902(a)(10)(A)(i)(III), (IV),  
(V), (VI), and (VII),  
1902(a)(10)(A)(ii)(IX),  
1902(a)(10)(A)(ii)(X),  
1902(a)(10)(C), 1902(f),  
1902(l) and (m), 1905(p)  
and (s), 1902(r)(2),  
and 1920

**2.6 Financial Eligibility**

- (a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in [ATTACHMENT 2.6-A](#).

TN #92-27

Supersedes TN #91-76

Approval Date January 20, 1993

Effective Date April 1, 1992

New York  
18

Citation

431.52 and  
1902(b) of the  
Act, P.L. 99-272  
(Section 9529)

**2.7 Medicaid Furnished Out of State**

Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

TN #86-29-A

Supersedes TN #82-24

Approval Date February 23, 1990

Effective Date October 1, 1986

New York  
19

SECTION 3 - SERVICES: GENERAL PROVISIONS

**Citation**

42 CFR  
Part 440,  
Subpart B  
1902(a), 1902(e),  
1905(a), 1905(p),  
1915, 1920, and  
1925 of the Act

1902(a)(10)(A) and  
1905(a) of the Act

**3.1 Amount, Duration and Scope of Services**

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

**(1) Categorically needy**

Services for the categorically needy are described below and in [ATTACHMENT 3.1-A](#). These services include:

- (i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.
- (ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

\_\_\_ Not applicable. Nurse-midwives are not authorized to practice in this State.

\*Effective February 3, 1995  
nurse-midwife services will be known  
as midwife services in New York State  
per Education Law, Article 140.

TN #95-08

Supersedes TN #94-35

Approval Date April 25, 1995

Effective Date February 3, 1995

New York  
19a

Citation

1902(e)(5) of  
the Act

3.1(a)(1) Amount, Duration, and Scope of Services:  
Categorically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60<sup>th</sup> day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

[X] (iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10),  
clause (VII)  
of the matter  
following (E)  
of the Act

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

TN #91-75

Supersedes TN #90-27

Approval Date March 3, 1992

Effective Date October 1, 1991

**Attachment 1.1**

**New York  
19b**

**Citation**

**3.1(a)(1) Amount, Duration, and Scope of Services:  
Categorically Needy (Continued)**

- |                                 |        |                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1902(e)(7) of the Act           | (vi)   | Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.                                                                                                                                                                                                                |
| 1902(e)(9) of the Act           | (vii)  | Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished. |
| 1902(a)(52) and 1925 of the Act | (viii) | Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.                                                                                                                                                                                                                            |
| 1905(a)(23) and 1929            | (ix)   | Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.                                                                                                                                                                                                                                 |
|                                 | (x)    | Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in <a href="#">Supplement 2 to Attachment 3.1-A</a> and Appendices A-G to <a href="#">Supplement 2 to Attachment 3.1-A</a> .                                                                                                           |

[ATTACHMENT 3.1-A](#) identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

TN #92-71

Approval Date March 23, 1993

Supersedes TN #91-75

Effective Date October 1, 1992

**Attachment 1.1**

**New York  
19c**

**Citation**

**3.1(a)(1) Amount, Duration, and Scope of Services:  
Categorically Needy (Continued)**

1905(a)(26) and 1934

X

Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in [Supplement 3 to Attachment 3.1-A](#).

[ATTACHMENT 3.1-A](#) identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically needy beneficiaries would specify all limitations on the amount, duration, and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage – that is in excess of established service limits – for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

TN #02-01

Approval Date September 3, 2002

Supersedes TN NEW

Effective Date January 1, 2002

New York  
20

Citation

42 CFR Part 440,  
Subpart B

1902(a)(10)(C)(iv)  
of the Act

1902(e)(5) of  
the Act

**3.1 Amount, Duration, and Scope of Services (continued)**

**(a)(2) Medically needy.**

[x] This State plan covers the medically needy.  
The services described below and in [ATTACHMENT 3.1-B](#) are provided.

Services for the medically needy include:

- (i) If services in an institution for mental diseases or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (20). The services are provided as defined in 42 CER Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.
  - [ ] Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.
- (ii) Prenatal care and delivery services for pregnant women.

TN #91-75

Supersedes TN #90-3

Approval Date March 3, 1992

Effective Date October 1, 1991

New York  
20a

Citation

3.1(a)(2) Amount, Duration, and Scope of Services:  
Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60<sup>th</sup> day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

[x] (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in [ATTACHMENT 3.1-B](#), for recipients under age 18 and recipients entitled to institutional services.

[ ] Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140,  
440.150,  
Subpart B,  
442.441,  
Subpart C 1902(a)(20)  
and (21) of the Act

[x] (vii) Services in an institution for mental diseases for individuals over age 65.

[x] (viii) Services in an intermediate care facility for the mentally retarded.

TN #91-75

Supersedes TN #87-47

Approval Date March 3, 1992

Effective Date October 1, 1991

**Attachment 1.1**

**New York  
20b**

**Citation**

**3.1(a)(2) Amount, Duration and Scope of Services:  
Medically Needy (Continued)**

1902(e)(9) of  
Act

- \_\_\_ (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1905(a)(23)  
and 1929 of the Act

- \_\_\_ (xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in [Supplement 2 to Attachment 3.1-A](#) and Appendices A-G to [Supplement 2 to Attachment 3.1-A](#).

[ATTACHMENT 3.1-B](#) identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

TN #93-27

Approval Date September 14, 1993

Supersedes TN #92-71

Effective Date April 1, 1993

**Attachment 1.1**

**New York  
20c**

**Citation**

**3.1(a)(2) Amount, Duration, and Scope of Services:  
Medically Needy (Continued)**

1905(a)(26) and 1934

X

Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in [Supplement 3 to Attachment 3.1-A](#).

[ATTACHMENT 3.1-B](#) identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitations, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage –that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.

TN #02-01

Approval Date September 3, 2002

Supersedes TN #NEW

Effective Date January 1, 2002

New York  
21

Citation

3.1 Amount, Duration, and Scope of Services

**(a)(3) Other Required Special Groups:  
Qualified Medicare Beneficiaries**

1902(a)(10)(E)(I)  
and clause (VIII)  
of the matter  
provided  
following (F),  
this  
and 1905(p)(3)  
of the Act

Medicare cost sharing for qualified  
Medicare beneficiaries described in  
section 1905(p) of the Act is  
only as indicated in item 3.2 of this  
plan.

1902(a)(10)  
(E)(ii) and  
1905(s) of the  
Act

**(a)(4)(I) Other Required Special Groups: Qualified  
Disabled and Working Individuals**

Medicare Part A premiums for  
qualified disabled and working  
individuals described in section  
1902(a)(10)(E)(ii) of the Act are  
provided as indicated in item 3.2  
of this plan.

1902(a)(10)  
(E)(iii) and  
1905(p)(3)(A)(ii)  
of the Act

**(ii) Other Required Special Groups: Specified  
Low-Income Medicare Beneficiaries**

Medicare Part B premiums for specified  
low-income Medicare beneficiaries  
described in section 1902 (a)(10)(E)(iii)  
of the Act are provided as indicated in  
item 3.2 of this plan.

1902(a)(10)  
(E)(iv)(I) and  
1905(p)(3)-(A)(ii),  
and 1933 of the Act

**(iii) Other Required Special Groups: Qualifying  
Individuals**

Medicare Part B premiums for qualifying  
individuals described in 1902(a)(10)(E)(iv)  
(I) and subject to 1933 of the Act are  
provided as indicated in item 3.2 of this  
plan.

TN #98-03

Approval Date May 15, 1998

Supersedes TN #93-27

Effective Date Jan 1, 1998

New York  
21 (continued)

1902(a)(10)  
(E)(iv)(II), 1905(p)(3)  
(A)(iv)(II), 1905(p)(3)  
the Act

**(iv) Other Required Special Groups: Qualifying  
Individuals – 2**

The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902(A)(10)(E)(iv)(II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

1925 of the  
Families  
Act

**(a)(5) Other Required Special Groups:**

Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

TN #98-03

Approval Date May 15, 1998

Supersedes TN NEW

Effective Date Jan 1, 1998

New York  
21a

Citation

3.1 Amount, Duration, and Scope of Services  
(Continued)

Sec. 245A(h)  
of the  
Immigration and  
Nationality Act

(a)(6) Limited Coverage for Certain Aliens

- (i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they—
  - (A) Are aged, blind, or disabled individuals as defined in section 1614 (a) (1) of the Act;
  - (B) Are children under 18 years of age; or
  - (C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983.
- (ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

TN #91-75

Supersedes TN #87-47

Approval Date March 3, 1992

Effective Date October 1, 1991

New York  
21b

Citation

3.1(a)(6) Amount, Duration, and Scope of Services:  
Limited  
Coverage for Certain Aliens (continued)

1902(a) and 1903(v)  
of the Act

(iii) Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.

1905(a)(9) of  
the Act

(a)(7) Homeless Individuals.

Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.

1902(a)(47)  
and 1920 of  
the Act

[x]

(a)(8) Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.

42 CFR 441.55  
50 FR 43654  
1902(a)(43),  
1905(a)(4)(B),  
and 1905(r) of  
the Act

(a)(9) EPSDT Services.

The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

TN #91-75

Approval Date March 3, 1992

Supersedes TN NEW

Effective Date October 1, 1991

**New York**  
**22**

**Citation****3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT Services (continued)**

42 CFR 441.60

- [x] The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.

42 CFR 440.240  
and 440.250**(a)(10) Comparability of Services**1902(a) and 1902  
(a)(10), 1902(a)(52),  
1903(v), 1915(g), and  
1925(b)(4) of the Act

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915 and 1925 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

- (i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.
- (ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.
- (iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.
- [x] (iv) Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

A variety of methods are employed, including –

- o review of enrollment and utilization data such as periodic reports.
- o validation by the New York State Department of Health of the provider's Quality Assurance Program through review of reports and on-site visits.
- o dissemination of informational materials to all individuals.
- o review of grievance procedures.

TN #91-75Approval Date March 3, 1992Supersedes TN #87-47Effective Date October 1, 1991

New York  
23

**Citation**  
42 CFR Part  
440, Subpart B  
42 CFR 441.15  
AT-78-90  
AT-80-34

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

- (1) Home health services are provided to all categorically needy individuals 21 years of age or over.
- (2) Home health services are provided to all categorically needy individuals under 21 years of age.

Yes

Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

Yes, to all

Yes, to individuals age 21 or over; SNF services are provided

Yes, to individuals under age 21; SNF services are provided

No; SNF services are not provided

Not applicable, the medically needy are not included under this plan

TN #79-37

Supersedes TN #77-23

Approval Date February 8, 1980

Effective Date October 1, 1979

New York  
24

**Citation**

42 CFR 431.53

42 CFR 483.10

**3.1 Amount, Duration, and Scope of Services**  
**(continued)**

**(c)(1) Assurance of Transportation**

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in [ATTACHMENT 3.1-C](#).

**(c)(2) Payment for Nursing Facility Services**

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10(c)(8)(i).

TN #93-60

Supersedes TN #91-75

Approval Date January 19, 1994

Effective Date October 1, 1993

New York  
25

**Citation**  
42 CFR 440.260  
AT-78-90

3.1(d) **Methods and Standards to Assure  
Quality of Services**

The standards established and the methods used to assure high quality care are described in [ATTACHMENT 3.1-C](#).

TN   #77-23    
Supersedes TN   #74-38  

Approval Date   December 28, 1977    
Effective Date   July 1, 1977

New York  
26

**Citation**

42 CFR 441.20

AT-78-90

**3.1(e) Family Planning Services**

The requirements of 42 CFR 441.20 are not regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

TN #77-23

Supersedes TN #74-38

Approval Date December 28, 1977

Effective Date July 1, 1977

New York  
27

**Citation**  
42 CFR 441.30  
AT-78-90

**3.1(f)(1) Optometric Services**

Optometric services (other than those provided under §435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

Yes.

No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

Not applicable. The conditions in the first sentence do not apply.

1903(i)(1)  
of the Act,  
P.L. 99-272  
(Section 9507)

**(2) Organ Transplant Procedures**

Organ transplant procedures are provided.

No.

Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at [ATTACHMENT 3.1-E](#).

TN #87-47  
Supersedes TN #77-23

Approval Date November 21, 1991  
Effective Date October 1, 1987

New York  
28

**Citation**

42 CFR 431.110(b)  
AT-78-90

1902(e)(9) of  
the Act,  
P.L. 99-509  
(Section 9408)

**3.1(g) Participation by Indian Health Service Facilities**

Indian Health Service Facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

**(h) Respiratory Care Services for Ventilator-Dependent Individuals**

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

- (1) Are medically dependent on a ventilator for life support at least six hours per day;
- (2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of—
  - [ ] 30 consecutive days;
  - [ ] \_\_ days (the maximum number of inpatient days allowed under the state plan);
- (3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF or ICF for which Medicaid payments would be made;
- (4) Have adequate social support services to be cared for at home; and
- (5) Wish to be cared for at home.

[ ] Yes. The requirements of section 1902(e)(9) of the Act are met.

[x] Not applicable. These services are not included in the plan.

TN #87-47

Supersedes TN #79-4

Approval Date November 21, 1991

Effective Date October 1, 1987

New York  
29

**3.2 Coordination of Medicaid with Medicare and Other Insurance**

**(a) Premiums**

**(1) Medicare Part A and Part B**

1902(a)(10)(E)(i) and  
1905(p)(1) of the Act

**(i) Qualified Medicare Beneficiary (QMB)**

The Medicaid agency pays Medicare Part A premiums (If applicable) and Part B premiums for Individuals in the QMB group defined in Item A.25 of [ATTACHMENT 2.2-A](#), through the group premium payment arrangement, unless the agency has a Buy-In agreement for such payment as indicated below.

Buy-in agreement for:

Part A  Part B

The Medicaid agency pays premiums for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

TN #04-09

Approval Date June 15, 2004

Supersedes TN #93-27

Effective Date April 1, 2004

New York  
29a**Citation**

1902(a)(10)(E)(ii)  
and 1905(s) of the Act

**(ii) Qualified Disabled and Working Individual (QDWI)**

The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in [ATTACHMENT 4.18-E](#), for individuals in the QDWI group defined in item A.26 of [ATTACHMENT 2.2-A](#) of this plan.

1902(a)(10)(E)(iii)  
and 1905(p)(3)(A)(ii)  
of the Act

**(iii) Specified Low-Income Medicare Beneficiary (SLMB)**

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of [ATTACHMENT 2.2-A](#) of this plan.

1902(a)(10)(E)(iv)(I),  
1905(p)(3)(A)(ii), and  
1933 of the Act

**(iv) Qualifying Individual - 1 (QI-1)**

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.

1902(a)(10)(E)(iv)(II),  
1905(p)(3)(A)(ii), and  
1933 of the Act

**(v) Qualifying Individual - 2 (QI-2)**

The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902(a)(10)(E)(iv)(II) and subject to 1933 of the Act.

TN     #98-03    

Supersedes TN     #93-27    

Approval Date     May 15, 1998    

Effective Date     January 1, 1998

New York  
29b

**Citation**

1843(b) and 1905(a)  
of the Act and  
42 CFR 431.625

**(vi) Other Medicaid Recipients**

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

- All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) within a group listed at 42 CFR 431.625(d)(2).
- Individuals receiving title II or Railroad Retirement benefits.
- Medically needy individuals (FFP is not available for this group).

1902(a)(30) and  
1905(a) of the Act

**(2) Other Health Insurance**

The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

TN   #98-03  

Supersedes TN   #93-27  

Approval Date   May 15, 1998  

Effective Date   January 1, 1998

**New York  
29c**

**Citation****(b) Deductibles, Coinsurance****(1) Medicare Part A and B**

1902(a)(30), 1902(n),  
1905(a), and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902  
(a)(10)(E)(i) and  
1905(p) of the Act

**(i) Qualified Medicare Beneficiaries (QMBS)**

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for the QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902(a)(10), 1902(a)(30),  
and 1905(a) of the Act

**(ii) Other Medicaid Requests**

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

42 CFR 431.625

[ ] For the entire range of services available under Medicare Part B.

[x] Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30),  
1905(a), and 1905(p)  
of the Act

**(iii) Dual Eligible – QMB plus**

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

TN #93-27

Approval Date September 14, 1993

Supersedes TN #91-75

Effective Date April 1, 1993

**New York  
29d**

Citation	Condition or Requirement
1906 of the Act	<p><b>(c) <u>Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations</u></b></p> <p>The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans.</p> <p>When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).</p>
1902(a)(10)(F) of the Act	<p><b>(d) [x]</b> The Medicaid agency pays premiums for individuals described in item 19 of <a href="#">Attachment 2.2-A</a>.</p>

TN   #91-54  

Supersedes TN   NEW  

Approval Date   July 27, 1995  

Effective Date   July 1, 1991

New York  
30

**Citation**

42 CFR 441.101,  
42 CFR 431.620(c)  
and (d)  
AT-79-29

**3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases**

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

TN #75-11

Supersedes TN #74-2

Approval Date April 17, 1975

Effective Date April 1, 1975

New York  
31

**Citation**  
42 CFR 441.252  
AT-78-99

**3.4 Special Requirements Applicable to Sterilization Procedures**

All requirements of 42 CFR Part 441, Subpart F are met.

TN #79-5  
Supersedes TN #77-23

Approval Date May 4, 1979  
Effective Date January 1, 1979

New York  
31a

**Citation**  
1902(a)(52)  
and 1925 of  
the Act

**3.5 Families Receiving Extended Medicaid Benefits**

- (a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in [ATTACHMENT 3.1-A](#) (or may be greater if provided through a caretaker relative employer's health insurance plan).
- (b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are --
  - Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in [ATTACHMENT 3.1-A](#) (or may be greater if provided through a caretaker relative employer's health insurance plan).
  - Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:
    - Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
    - Medical or remedial care provided by licensed practitioners.
    - Home health services.

TN   #91-75    
Supersedes TN   #87-47  

Approval Date   March 3, 1992    
Effective Date   October 1, 1991

New York  
31b

Citation

3.5 Families Receiving Extended Medicaid Benefits  
(Continued)

- Private duty nursing services.
- Physical therapy and related services.
- Other diagnostic, screening, preventive, and rehabilitation services.
- Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- Intermediate care facility services for the mentally retarded.
- Inpatient psychiatric services for individuals under age 21.
- Hospice services.
- Respiratory care services.
- Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

TN #91-75

Supersedes TN #90-3

Approval Date March 3, 1992

Effective Date October 1, 1991

New York  
31c

Citation

3.5 Families Receiving Extended Medicaid Benefits  
(Continued)

(c)  The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance --

1st 6 months       2nd 6 months

The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

1st 6 mos.       2nd 6 mos.

(d)  (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

Enrollment in the family option of an employer's health plan.

Enrollment in the family option of a State employee health plan.

Enrollment in the State health plan for the uninsured.

Enrollment in an eligible health Maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

TN #91-75

Supersedes TN #87-47

Approval Date March 3, 1992

Effective Date October 1, 1991

New York  
31d

Citation

**3.5 Families Receiving Extended Medicaid Benefits (Continued)**

[Supplement 2 to Attachment 3.1-A](#) specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency –

(i) Pays all premiums and enrollments fees imposed on the family for such plan(s)

[ ] (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s)

**3.6 Unemployed Parent**

For purposes of determining whether a child is deprived on the basis of the unemployment of a parent, the agency –

[ ] Uses the standard for measuring unemployment which was in the AFDC State Plan in effect on July 16, 1996

[x] Uses the following more liberal standard to measure unemployment:

An individual will be considered unemployed if the family's countable income and resources as determined for the group defined in Section 1931 are below the eligibility standard used for that group

([Attachment 2.6-A, Supplement 12](#) and [Supplement 1 to Attachment 2.6-A](#), Item A-1) or if the family's income and resources, minus deductions allowed for medically needy, including incurred medical expenses, is less than the medically needy income level

([Supplement 1 to Attachment 2.6-A](#), Item D) and Resource level ([Supplement 2 to Attachment 2.6-A](#), Item B).

(Note: This effectively eliminates the old AFDC deprivation requirements from all groups.)

TN #99-41

Approval Date March 31, 2000

Supersedes TN #91-75

Effective Date October 1, 1999

**New York  
31e**

- [x] Enrollment in an eligible health maintenance organization (HMO) that has an enrollment of less than 50 percent of Medicaid recipients who are not recipients of extended Medicaid.\*

[Supplement 2 to ATTACHMENT 3.1-A](#) specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

- [ ] (i) Pays all premiums and enrollment fees imposed on the family for such plan(s).
- [ ] (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

\* Only if previously enrolled

TN   #90-27  

Supersedes TN   NEW  

Approval Date   July 20, 1990  

Effective Date   April 1, 1990

New York  
32

**SECTION 4 – GENERAL PROGRAM ADMINISTRATION**

**Citation**

**4.1 Methods of Administration**

42 CFR 431.15  
AT-79-29

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

42 USC 1396a(13)(A)

The State provides for a public process that conforms to the requirements of section 4711 of the federal Balanced Budget Act of 1997 for determination of rates of payment under this Plan for [Attachments 4.19-A](#) Parts 1, 2, 3, 4, 5, 7 and [Attachment 4.19-D](#) Parts 1 and 2.

TN #97-37

Approval Date February 9, 1998

Supersedes TN #87-47

Effective Date October 1, 1997

New York  
33

**Citation**

42 CFR 431.202  
AT-79-29  
AT-80-31

**4.2 Hearings for Applicants and Recipients**

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

TN #74-16

Supersedes TN #74-2

Approval Date April 3, 1975

Effective Date April 1, 1974

New York  
33a

Citation

P.L. 101-508  
Section 4724

Services During Appeal

The State shall continue to provide medical assistance until a final determination of disability or blindness is made by SSA in those cases where a state determination of disability or blindness, made in accordance with section 1614(a) of the Social Security Act, was reversed by a subsequent SSA decision.

YES  
 NO

TN #91-30

Supersedes TN NEW

Approval Date July 22, 1991

Effective Date April 1, 1991

New York  
34

Citation

**4.3 Safeguarding Information on Applicants and Recipients**

42 CFR 431.301  
AT-79-29

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

52 FR 5967

All other requirements of 42 CFR Part 431, Subpart F are met.

TN #87-49

Approval Date June 4, 1991

Supersedes TN #74-2

Effective Date October 1, 1987

New York  
35

**Citation**

42 CFR 431.800(c)  
50 FR 21839  
1903(u)(1)(D) of  
the Act,  
P.L. 99-509  
(Section 9407)

**4.4 Medicaid Quality Control**

- (a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.
- (b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h) and (k).

Yes.

Not applicable. The State has an approved Medicaid Management Information System (MMIS).

TN #87-47

Supersedes TN #85-21

Approval Date November 21, 1991

Effective Date October 1, 1987

New York  
36

**Citation**

42 CFR 455.12  
AT-78-90  
48 FR 3742  
52 FR 48817

**4.5 Medicaid Agency Fraud Detection and Investigation Program**

The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

TN #89-43  
Supersedes TN #83-34

Approval Date March 13, 1992  
Effective Date July 1, 1989

New York  
36-1

PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

<p><u>Citation</u></p> <p>Section 1902(a)(42)(B)(i) of the Social Security Act</p>	<p><input checked="" type="checkbox"/> The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.</p> <p><input type="checkbox"/> The State is seeking an exception to establishing such program for the following reasons:</p>
<p>Section 1902(a)(42)(B)(ii)(I) of the Act</p>	<p><input checked="" type="checkbox"/> The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.</p> <p>Place a check mark to provide assurance of the following:</p> <p><input checked="" type="checkbox"/> The State will make payments to the RAC(s) only from amounts recovered.</p> <p><input checked="" type="checkbox"/> The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.</p>

TN #10-43 \_\_\_\_\_

Approval Date March 8, 2011

Supersedes TN NEW

Effective Date April 1, 2011

New York  
36-2

PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

<p>Section 1902 (a)(42)(B)(ii)(II)(a) of the Act</p>	<p>The following payment methodology shall be used to determine State payments to Medicaid RACs for recovered overpayments (e.g., the percentage of the contingency fee):</p> <p><input checked="" type="checkbox"/> The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.</p> <p><input type="checkbox"/> The State attests that if the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.</p> <p><input type="checkbox"/> The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.</p>
<p>Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act</p>	<p><input checked="" type="checkbox"/> The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):</p> <p>Contingency Fee – 5.25%</p>

TN #10-43

Approval Date March 8, 2011

Supersedes TN NEW

Effective Date April 1, 2011

New York  
36-3

PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

<p>Section 1902 (a)(42)(B)(ii)(III) of the Act</p>	<p><u>  X  </u> The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RACs.</p>
<p>Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act</p>	<p><u>  X  </u> The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.</p>
<p>Section 1902 (a)(42)(B)(ii)(IV)(bb) of the Act</p>	<p><u>  X  </u> The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.</p>
<p>Section 1902 (a)(42)(B)(ii)(IV)(cc) of the Act</p>	<p><u>  X  </u> Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.</p>

TN   #10-43  

Approval Date   March 8, 2011  

Supersedes TN   NEW  

Effective Date   April 1, 2011

**SECTION 4 – GENERAL PROGRAM ADMINISTRATION**

**4.5 Medicaid Recovery Audit Contractor Program (Exceptions)**

<u>Citation</u>	<u>Exception from Medicaid RAC 3-year Look Back Period</u>
<p>42 CFR 455.508(f)</p>	<p><u>New York State requests an exception to the 3-year look back period for the Medicaid RAC program defined in section 455.508. Subparagraph (f) states, "The entity must not review claims that are older than 3 years from the date of the claim, unless it receives approval from the State."</u></p> <p><u>New York State regulations (18 NYCRR Section 504.3) require providers "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health".</u></p> <p><u>The State requests the ability to grant a look back period for the Medicaid RAC up to six years, upon State approval of the RAC scenario, for the following reasons:</u></p> <ul style="list-style-type: none"> <li><u>• Claim specific detail may be present documenting an overpayment exists for periods beyond the three-years specified in Section 42 CFR 455.508(f):</u></li> <li><u>• A look-back period longer than three years is more consistent with Medicaid provider record retention requirements required by New York State regulatory agencies; and</u></li> <li><u>• A longer look-back period will allow for additional efficiencies for both the state and provider when a single effort can review and recover an identified overpayment rather than leveraging multiple entities to review and recover different time periods.</u></li> </ul> <p><u>This exception will only apply to reviews based on actual claim specific detail. Audits that require sampling and extrapolation will continue to be limited to the 3-year look back period.</u></p>

TN #12-36

Approval Date March 19, 2013

Supersedes TN NEW

Effective Date January 1, 2013

New York  
36a

**Citation**

Section 1902(a)(64) of  
the Social Security Act  
P.L. 105-33

**4.5a Medicaid Agency Fraud Detection and  
Investigation Program**

The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

TN #99-30

Supersedes TN NEW

Approval Date December 6, 1999

Effective Date July 1, 1999

New York  
37

**Citation**

42 CFR 431.16  
AT-79-29

**4.6 Reports**

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

TN #76-54

Supersedes TN #75-38

Approval Date January 28, 1977

Effective Date October 1, 1976

New York  
38

**Citation**

42 CFR 431.17  
AT-79-29

**4.7 Maintenance of Records**

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

TN #74-2

Supersedes TN None

Approval Date December 31, 1974

Effective Date prior to January 1, 1974

New York  
39

**Citation**

42 CFR 431.18(b)  
AT-79-29

**4.8 Availability of Agency Program Manuals**

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

TN #74-2

Supersedes TN None

Approval Date December 31, 1974

Effective Date prior to January 1, 1974

New York  
40

**Citation**  
42 CFR 433.37  
AT-78-90

**4.9 Reporting Provider Payments to Internal Revenue Service**

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

TN #74-2  
Supersedes TN None

Approval Date December 31, 1974  
Effective Date prior to January 1, 1974

New York  
41

**Citation**

42 CFR 431.51  
AT-78-90  
46 FR 48524  
48 FR 23212  
1902(a)(23)  
of the Act  
P.L. 100-93  
(section 8(f))  
P.L. 100-203  
(Section 4113)

Section 1902(a)(23)  
of the Social Security Act  
P.L. 105-33

**4.10 Free Choice of Providers**

- (a) Except as provided in paragraph (b), the Medicaid agency assures that an individual under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.
- (b) Paragraph (a) does not apply to services furnished to an individual –
  - (1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or
  - (2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or
  - (3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act, or
  - (4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services.
- (c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1915(b)(1), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

TN   #99-30    
Supersedes TN   12-01  

Approval Date   December 6, 1999    
Effective Date   July 1, 1999

New York  
42

**Citation**

42 CFR 431.610  
AT-79-90  
AT-80-34

**4.11 Relations with Standard Setting and Survey agencies**

- (a) The State Agency utilized by the Secretary to determine qualifications of institutions and supplies of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provides services to Medicaid recipients. This agency is: The New York State Department of Health.
- (b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is(are): The New York State Department of Health and The Office of Mental Health.
- (c) [Attachment 4.11-A](#) describes the standards specified in paragraphs (a) and (b) above, are kept on file and made available to the Health Care Financing Administration, on request.

TN #97-10  
Supersedes TN 86-7

Approval Date July 8, 1997  
Effective Date October 1, 1996

New York  
43

**Citation**

42 CFR 431.610

AT-78-90

AT-89-34

**4.11**

- (d) The New York State Department of Health (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

TN #74-14

Supersedes TN 74-2

Approval Date April 12, 1976

Effective Date April 1, 1974

New York  
44

**Citation**

42 CFR 431.105(b)  
AT-78-90

**4.12 Consultation to Medical Facilities**

- (a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).
- (b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

Yes, as listed below:

- 1. Public Home infirmaries.
- 2. Infirmary section of a private home for aged.
- 3. Institutions for mental diseases including sections for mental diseases of general hospitals.
- 4. Institutions for Tuberculosis including sections for Tuberculosis in general hospitals.
- 5. Medical rehabilitation centers.
- 6. Such other facilities authorized by State law in which care or treatment may be provided.

Not applicable. Similar services are not provided to other types of medical facilities.

TN #74-2

Approval Date December 31, 1974

Supersedes TN None

Effective Date prior to January 1, 1974

New York  
45

Citation

**4.13 Required Provider Agreement**

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

- |                                       |                                                                                                                                                                                                                  |
|---------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 42 CFR 431.107                        | (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.                                                                                         |
| 42 CFR Part 483<br>1919 of the<br>Act | (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.                                                                                      |
| 42 CFR Part 483,<br>Subpart D         | (c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.                                                                                              |
| 1920 of the Act                       | (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met. |
|                                       | [ ] Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.                                                                                          |

TN   #91-75  

Approval Date   March 3, 1992  

Supersedes TN   87-47  

Effective Date   October 1, 1991

New York  
45a

**Citation**

1902(a)(58)  
1902(w)

**4.13**

- (e) For each provider receiving funds under the plan, all the requirements for advance directive of section 1902(w) are met:
  - (1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations are required to do the following:
    - (a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
    - (b) Provide written information to all adult individuals on their policies concerning implementation of such rights;
    - (c) Document in the individual's medical records whether or not the individual has executed an advance directive;
    - (d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
    - (e) Ensure compliance with requirements of State Law (whether

TN   #91-81    
Supersedes TN   NEW  

Approval Date   January 15, 1992    
Effective Date   December 1, 1991

**New York  
45b**

statutory or recognized by the courts)  
concerning advance directives; and

- (f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.
- (2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:
- (a) Hospitals at the time an individual is admitted as an inpatient.
  - (b) Nursing facilities when the individual is admitted as a resident.
  - (c) Providers of home health care or personal care services before the individual comes under the care of the provider;
  - (d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and
  - (e) Health maintenance organizations at the time of enrollment of the individual with the organization.
- (3) [Attachment 4.34A](#) describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

— Not applicable. No State law or court decision exist regarding advance directives.

New York  
46

**Citation**

42 CFR 431.60  
42 CFR 456.2  
50 FR 15312  
1902(a)(30)(C) and  
1902(d) of the  
Act, P.L. 99-509  
(Section 9431)

**4.13 Utilization/Quality Control**

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

  x   Directly

  x   By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO –

- (1) Meets the requirements of §434.6(a);
- (2) Includes a monitoring and evaluation plan to ensure satisfactory performance;
- (3) Identifies the services and providers subject to PRO review;
- (4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and
- (5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

  x   Quality review requirements described in section 1902(a)(30)(C) of the Act relating to services furnished by HMOs under contract are undertaken through contract with the PRO designed under 42 CFR Part 462.

\_\_\_\_\_ By undertaking quality review of services furnished under each contract with an HMO through a private accreditation body.

1902(a)(30)(C)  
and 1902(d) of the  
Act, P.L. 99-509  
(section 9431)

TN   #92-09  

Supersedes TN   89-43  

Approval Date   April 30, 1992  

Effective Date   January 1, 1992

New York  
47

**Citation**

42 CFR 456.2  
50 FR 15312

**4.14**

- (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.
- [ ] Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.
  - [ ] Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:
    - [ ] All hospitals (other than mental hospitals).
    - [ ] Those specified in the waiver.
  - [X] No waivers have been granted.

TN #85-32

Supersedes TN 76-23

Approval Date March 6, 1986

Effective Date October 1, 1985

New York  
48

**Citation**

42 CFR 456.2  
50 FR 15312

**4.14**

- (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.
- Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.
- Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:
- All mental hospitals.
- Those specified in the waiver.
- No waivers have been granted.
- Not applicable. Inpatient services in mental hospitals are not provided under this plan.

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Supersedes TN 76-23

Approval Date March 6, 1986  
Effective Date October 1, 1985

New York  
49

**Citation**

42 CFR 456.2  
50 FR 15312

**4.14**

(d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

All skilled nursing facilities.

Those specified in the waiver.

No waivers have been granted.

TN #85-32

Supersedes TN 76-23

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Effective Date October 1, 1985

New York  
50

**Citation**

42 CFR 456.2  
50 FR 15312

**4.14**

- (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:
- Facility-based review.
  - Direct review by personnel of the medical assistance unit of the State agency.
  - Personnel under contract to the medical assistance unit of the State agency.
  - Utilization and Quality Control Peer Review Organizations.
  - Another method as described in [ATTACHMENT 4.14-A](#).
- \*  Two or more of the above methods. [ATTACHMENT 4.14-B](#) describes the circumstances under which each method is used.
- Not applicable. Intermediate care facility services are not provided under this plan.

\* See approval letter

TN   #85-32  

Supersedes TN   76-23  

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Effective Date   October 1, 1985

New York  
50a

**Citation**

1902(a)(30)  
and 1902(d) of  
the Act,  
P.L. 99-509  
(Section 9431)  
P.L. 99-203  
(section 4113)

**4.14 Utilization/Quality Control (continued)**

(f) The Medicaid agency meets the requirements of section 1902(a)(30) of section 1902(a)(30) of the Act for control of the assurance of quality furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality reviews are performed annually by:

  X   A Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

     A private accreditation body.

     An entity that meets the requirements of the Act, as determined by the Secretary.

The Medicaid agency certifies that the entity in the preceding subcategory under 4.14(f) is not an agency of the State.

TN   #92-09  

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New York  
51

Citation

4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part  
456 Subpart  
I, and  
1902(a)(31)  
and 1903(g)  
of the Act

\_\_\_ The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:

\_\_\_ ICFs/MR;

\_\_\_ Inpatient psychiatric facilities for recipients under age 21; and

\_\_\_ Mental Hospitals

42 CFR Part  
456 Subpart  
A and  
1902(a)(30)  
of the Act

X All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

\_\_\_ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

\_\_\_ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.

\_\_\_ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

TN #92-23

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Effective Date April 1, 1992

New York  
52

**Citation**

42 CFR 431.615(c)  
AT-78-90

**4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees**

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615

The Medicaid agency will provide for coordination of the operations under Title XIX with the State's operations under the special supplemental food program for women, infants and children (WIC) under Section 17 of the Child Nutrition Act of 1966 as specified by amendment to Section 1902(a)(11) of the Social Security Act.

[ATTACHMENT 4.16-A](#) describes the cooperative arrangements with the health and vocational rehabilitation agencies.

TN #90-25

Supersedes TN 74-2

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Effective Date July 1, 1990

New York  
53

**Citation**

42 CFR 433.36(c)  
1902(a)(18) and  
1917(a) and (b) of  
the Act

**4.17 Liens and Adjustments or Recoveries**

**(a) Liens**

X The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid to or be paid on his or her behalf.

X The State imposes liens on real property on account of benefits incorrectly paid.

X The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in [Attachment 4.17-A](#). (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

X The State imposes liens on both real and personal property of an individual after the individual's death.

TN #95-28

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53a

**(b) Adjustments or Recoveries**

The State complies with the requirement of section 1917(b) of the Act and regulations at 42 CFR 433.36 (h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

- (1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

- X   Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

- (2)   X   The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1)(B) (even if it does not impose those liens).

- (3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

- X   In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:  
Payment for all services are recovered for individuals age 55 and over, except for Medicare cost sharing as specified in section 4.17(b)(3) – continued)

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53a-1

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery – Medicare Cost Sharing:

- (i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB +, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.
  
- (ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

New York  
53b

- (4)  The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in [Attachment 2.6-A, supplement 8b](#).
- The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)
- The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.
- The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

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53c

(c) **Adjustments or Recoveries: Limitations**

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h)-(i).

- (1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.
- (2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:
  - (a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or
  - (b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care of the child provided permitted the individual to reside at home rather than become institutionalized.
- (3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

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New York  
53d

(d) [ATTACHMENT 4.17-A](#)

- (1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).
- (2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).
- (3) Defines the following terms:
  - estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
  - individual's home,
  - equity interest in the home,
  - residing in the home for at least 1 or 2 years,
  - on a continuous basis,
  - discharge from the medical institution and return home, and
  - lawfully residing.

**New York  
53e**

- (4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.
- (5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.
- (6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

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**New York**  
**54**

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*Refer to Attachment 8.1-Cost Sharing*

[www.health.ny.gov/regulations/state\\_plans/status/portal/index.htm#cost](http://www.health.ny.gov/regulations/state_plans/status/portal/index.htm#cost)

**Reserved**

**[Citation]**

42 CFR 447.51  
through 447.55

1916(a) and  
of the Act

**4.18 Recipient Cost Sharing and Similar Charges**

- (a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54
- (b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:
- (1) No enrollment fee, premium, or similar charge is imposed under the plan.
- (2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:
- (i) Services to individuals under age 18, or under –
- [ ] Age 19
- [ ] Age 20
- [X] Age 21
- Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.
- (ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.]

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**New York**  
**55**

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[www.health.ny.gov/regulations/state\\_plans/status/portal/index.htm#cost](http://www.health.ny.gov/regulations/state_plans/status/portal/index.htm#cost)

**Reserved**

**[Citation]**

**4.18 (b)(2) (Continued)**

42 CFR 447.51  
through  
447.58

- (iii) All services furnished to pregnant women.  
  
[ ] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.
- (iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.
- (v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).
- (vi) Family planning services and supplies furnished to individuals of childbearing age.
- (vii) Services furnished by a health maintenance organization in which the individual is enrolled.
- (viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.]

1916 of the Act,  
P.L. 99-272,  
(Section 9505)

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[www.health.ny.gov/regulations/state\\_plans/status/portal/index.htm#cost](http://www.health.ny.gov/regulations/state_plans/status/portal/index.htm#cost)

**Reserved**

**[Citation]**

**4.18 (b) (Continued)**

42 CFR 447.51  
through  
447.46

- (3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(3) above.
- [ ] Not applicable. No such charges are imposed.
- (i) For any service, no more than one type of charge is imposed.
- (ii) Charges apply to services furnished to the following age groups:
- [ ] 18 or older
- [ ] 19 or older
- [ ] 20 or older
- [X] 21 or older
- [ ] Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.]

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56a

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[www.health.ny.gov/regulations/state\\_plans/status/portal/index.htm#cost](http://www.health.ny.gov/regulations/state_plans/status/portal/index.htm#cost)

**Reserved**

**[Citation]**

**4.18(b)(3) (Continued)**

42 CFR 447.51  
through 447.58

(iii) For the categorically needy and qualified Medicare beneficiaries, [ATTACHMENT 4.18-A](#) specifies the:

- (A) Service(s) for which a charge(s) is applied;
- (B) Nature of the charge imposed on each service;
- (C) Amount(s) of and basis for determining the charge(s);
- (D) Method used to collect the charge(s);
- (E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;
- (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
- (G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

[ ] Not applicable. There is no maximum.]

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56b**

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**Reserved**

**[Citation**

1902(c) of  
the Act

4.18(b)(4) [ ] A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. [ATTACHMENT 4.18-D](#) specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.

1902(a)(52)  
and 1925(b)  
of the Act

4.18(b)(5) [ ] For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.

1916(d) of  
the Act

4.18(b)(6) [ ] A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. [ATTACHMENT 4.18-E](#) specifies the method and standards the State uses for determining the premium.]

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[www.health.ny.gov/regulations/state\\_plans/status/portal/index.htm#cost](http://www.health.ny.gov/regulations/state_plans/status/portal/index.htm#cost)

**Reserved**

**[Citation]**

42 CFR 447.51  
through 447.58

**4.18(c)** [X] Individuals are covered as medically needy under the plan.

(1) [ ] An enrollment fee, premium or similar charge is imposed. [ATTACHMENT 4.18-B](#) specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State’s policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through  
447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under –

[ ] Age 19

[ ] Age 20

[X] Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:]

TN #15-0011

Approval Date June 9, 2020

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**New York  
56d**

***NOTE: Page deleted under approved SPA 15-0011***  
***Approved Date: 6/9/20    Effective Date: 10/1/15***  
***Refer to Attachment 8.1-Cost Sharing***

[www.health.ny.gov/regulations/state\\_plans/status/portal/index.htm#cost](http://www.health.ny.gov/regulations/state_plans/status/portal/index.htm#cost)

**Reserved**

**[Citation]**

**4.18(c)(2) (Continued)**

42 CFR 447.51  
through  
447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

[ ] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act,  
P.L. 99-272  
(Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

447.51 through  
447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

[ ] Not applicable. No such charges are imposed.]

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[www.health.ny.gov/regulations/state\\_plans/status/portal/index.htm#cost](http://www.health.ny.gov/regulations/state_plans/status/portal/index.htm#cost)

**Reserved**

**[Citation]**

**4.18(c)(3)** Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

[ ] Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

[ ] 18 or older

[ ] 19 or older

[ ] 20 or older

[X] 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.]

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56f**

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[www.health.ny.gov/regulations/state\\_plans/status/portal/index.htm#cost](http://www.health.ny.gov/regulations/state_plans/status/portal/index.htm#cost)

**Reserved**

**[Citation]**

**4.18(c)(3) (Continued)**

447.51 through  
447.58

- (iii) For the medically needy, and other optional groups, [ATTACHMENT 4.18-C](#) specifies the:
  - (A) Service(s) for which charge(s) is applied;
  - (B) Nature of the charge imposed on each service;
  - (C) Amount(s) of and basis for determining the charge(s);
  - (D) Method used to collect the charge(s);
  - (E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;
  - (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
  - (G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.
  
- [ ] Not applicable. There is no maximum.]

**TN #15-0011**

**Approval Date June 9, 2020**

**Supersedes TN #92-285**

**Effective Date October 1, 2015**

New York  
57

**Citation**

42 CFR 447.252  
1902(a)(13)  
and 1923 of  
the Act

**4.19 Payment for Services**

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

[ATTACHMENT 4.19-A](#) describes the methods and standards used to determine rates for payment for inpatient hospital services.

[X] Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

[ ] Inappropriate level of care days are not covered.

TN #91-75

Supersedes TN #87-47

Approval Date March 3, 1992

Effective Date October 1, 1991

New York  
58

**Citation**

42 CFR 447.201  
42 CFR 447.302  
52 FR 28648  
1902(a)(13)(E)  
1903(a)(1) and  
(n), 1920, and  
1926 of the Act

4.19(b) In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:

- (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. [ATTACHMENT 4.19-B](#) describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).
- (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

[ATTACHMENT 4.19-B](#) describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

1902(a)(10) and  
1902(a)(30) of  
the Act

[SUPPLEMENT 1 to ATTACHMENT 4.19-B](#) describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

TN     #93-48      
Supersedes TN     #91-75    

Approval Date     December 10, 1993      
Effective Date     July 1, 1993

New York  
59

**Citation**

42 CFR 447.40  
AT-78-90

4.19(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

Yes. The State's policy is described in [ATTACHMENT 4.19-C](#).

No.

TN #78-23

Supersedes TN #77-8

Approval Date September 29, 1978

Effective Date September 1, 1978

New York  
60

Citation

4.19(d)

42 CFR 447.252  
47 FR 47964  
48 FR 56046  
42 CFR 447.280  
47 FR 31518  
52 FR 28141

- (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

[ATTACHMENT 4.19-D](#) describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

- (2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

- (3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

- (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

TN #87-49

Supersedes TN #84-2

Approval Date June 4, 1991

Effective Date October 1, 1987

**New York  
61**

**Citation**

42 CFR 447.45(c)  
AT-79-50

4.19(e)

The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.

[ATTACHMENT 4.19-E](#) specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

TN #81-17

Supersedes TN N/A

Approval Date March 18, 1983

Effective Date October 1, 1981

New York  
62

**Citation**

42 CFR 447.15  
AT-78-90  
AT-80-34  
48 FR 5730

4.19(f)

The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

TN #87-47

Supersedes TN #83-16

Approval Date November 21, 1991

Effective Date October 1, 1987

**New York**  
**63**

**Citation**

42 CFR 447.201  
42 CFR 447.202  
AT-78-90

4.19(g)

The Medicaid agency assures appropriate audits of records when payment is based on costs of services or on a fee plus cost of materials.

TN #79-24

Supersedes TN #78-18

Approval Date October 16, 1979

Effective Date August 6, 1979

**New York  
64**

**Citation**

42 CFR 447.201  
42 CFR 447.203  
AT-78-90

4.19(h)

The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

TN #79-24

Supersedes TN #78-18

Approval Date October 16, 1979

Effective Date August 6, 1979

**New York  
65**

**Citation**

42 CFR 447.201  
42 CFR 447.204  
AT-78-90

4.19(i)

The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

TN #79-24

Supersedes TN #78-18

Approval Date October 16, 1979

Effective Date August 6, 1979

New York  
66

**Citation**

42 CFR  
447.201  
and 447.205

4.19(j)

The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.

1903(v) of the  
Act

(k)

The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

TN #91-75

Supersedes TN #87-49

Approval Date March 3, 1992

Effective Date October 1, 1991

**New York  
66(a)**

**Citation**

1903(i)(14)  
of the Act

4.19(l)

The Medicaid agency meets the requirements of section 1903(i)(14) of the Act\* with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

\* and Section 6400 of the State Medicaid Manual

TN #92-71

Approval Date March 23, 1993

Supersedes TN NEW

Effective Date October 1, 1992

**New York  
66(b)**

**Citation**

**4.19(m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program**

1928(c)(2)  
(C)(ii) of  
the Act

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

  X   sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

       is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

       sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

       is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine:

1926 of  
the Act

(iii) **Medicaid beneficiary access to immunizations is assured through the following methodology:**

If indicated, the State will show, via the obstetrical/pediatric State Plan amendment submittal, that the VFC administration fee meets the applicable statutory requirements of the Social Security Act.

TN   #94-47  

Approval Date   January 30, 1995  

Supersedes TN   NEW  

Effective Date   October 1, 1994

New York  
67

**Citation**

42 CFR 447.25(b)  
AT-78-90

**4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services**

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25

Yes, for  physicians' services

dentists' services

[ATTACHMENT 4.20-A](#) specifies the conditions under which such payments are made.

Not applicable. No direct payments are made to recipients.

TN #74-25

Supersedes TN #74-14

Approval Date April 21, 1975

Effective Date January 1, 1974

New York  
68

**Citation**

42 CFR 447.10(c)  
AT-78-90  
46 FR 42699

**4.21 Prohibition Against Reassignment of  
Provider Claims**

Payment for Medicaid services  
furnished by any provider under this  
plan is made only in accordance with  
the requirements of 42 CFR 447.10.

TN #81-33

Supersedes TN #78-79

Approval Date May 7, 1982

Effective Date January 1, 1982

**New York**  
**69**

**Citation****4.22 Third Party Liability**

42 CFR 433.137

- (a) The Medicaid agency meets all requirements of:
- (1) 42 CFR 433.138 and 433.139.
  - (2) 42 CFR 433.145 through 433.148.
  - (3) 42 CFR 433.151 through 433.154.
  - (4) Sections 1902(a)(25)(H) and (I) of the Act.

1902(a)(25)(H) and (I)  
of the Act

42 CFR 433.138(f)

- (b) [ATTACHMENT 4.22-A](#) –

- (1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3), and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii)  
and (2)(ii)

- (2) Describes the method the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(3)(i)  
and (iii)

- (3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

42 CFR 433.138(g)(4)(i)  
through (iii)

- (4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

TN   #94-12  Approval Date   May 9, 1994  Supersedes TN   #87-49  Effective Date   January 1, 1994

New York  
69a

**Citation**

- |                             |          |                                                                                                                                                                                                                                                        |
|-----------------------------|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 42 CFR 433.139(b)(3)(ii)(A) | <u>X</u> | (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.                                   |
|                             |          | (d) <a href="#">ATTACHMENT 4.22-B</a> specifies the following:                                                                                                                                                                                         |
| 42 CFR 433.139(b)(3)(ii)(C) |          | (1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).                                                                                                                         |
| 42 CFR 433.139(f)(2)        |          | (2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective. |
| 42 CFR 433.139(f)(3)        |          | (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.                                                                              |
| 42 CFR 447.20               |          | (e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.                                                                                          |

TN   #94-12    
Supersedes TN   #87-49  

Approval Date   May 9, 1994    
Effective Date   January 1, 1994

New York  
70

Citation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

Other appropriate State agency(s) --  
\_\_\_\_\_  
\_\_\_\_\_

Other appropriate agency(s) of another State --  
\_\_\_\_\_  
\_\_\_\_\_

Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

The Secretary's method as provided in the State Medicaid Manual, Section 3910.

The State provides methods for determining cost effectiveness on [ATTACHMENT 4.22-C](#).

TN #94-12

Approval Date May 9, 1994

Supersedes TN #86-9

Effective Date January 1, 1994

New York  
71

**Citation**

42 CFR Part 434.4  
48 FR 54013

**4.23 Use of Contracts**

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

[ ] Not applicable. The State has no such contracts.

TN #84-3

Supersedes TN #78-26

Approval Date May 24, 1984

Effective Date April 1, 1984

New York  
72

**Citation**

42 CFR 442.10  
and 442.100  
AT-78-90  
AT-79-18  
AT-80-25  
AT-80-34  
52 FR 32544  
P.L. 100-203  
(Sec. 4211)  
54 FR 5316  
56 FR 48826

**4.24 Standards for Payments for Nursing Facility  
and Intermediate Care Facility for the Mentally  
Retarded Services**

With respect to nursing facilities and  
intermediate care facilities for the mentally  
retarded, all applicable requirements of  
42 CFR Part 442, Subparts B and C are met.

— Not applicable to intermediate care  
facilities for the mentally retarded;  
such services are not provided under this  
plan.

TN #94-32  
Supersedes TN #80-4

Approval Date September 8, 1994  
Effective Date April 1, 1994

New York  
73

**Citation**

42 CFR 431.702  
AT-78-90

**4.25 Program for Licensing Administrators of Nursing Homes**

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

TN #74-2

Supersedes TN None

Approval Date December 31, 1974

Effective Date Prior to January 1, 1974

**New York**  
**74**

**Citation**

1927(g)  
42 CFR 456.700

**4.26 Drug Utilization Review Program**

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:

- Appropriate
- Medically necessary
- Are not likely to result in adverse medical results

1927(g)(1)(a)  
42 CFR 456.705(b) and  
456.709(b)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

- Potential and actual adverse drug reactions
- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse

1927(g)(1)(B)  
42 CFR 456.703  
(d) and (f)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:

- American Hospital Formulary Service Drug Information
- United States Pharmacopeia-Drug Information
- American Medical Association Drug Evaluations

TN   #93-21  

Approval Date   September 13, 1993  

Supersedes TN   #92-23  

Effective Date   April 1, 1993

**New York  
74a**

**Citation**

1927(g)(1)(D)  
42 CFR 456.703(b)

- D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in:

Prospective DUR  
 Retrospective DUR. \*

1927(g)(2)(A)  
42 CFR 456.705(b)

- E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before prescription is filled or delivered to the Medicaid recipient.

1927(g)(2)(A)(i)  
42 CFR 456.705(b),  
(1)-(7))

2. Prospective DUR includes screening each prescription filled delivered to an individual receiving benefits for potential drug therapy problems due to:

- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Drug-interactions with non-prescription or over-the-counter drugs
- Incorrect drug dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse/misuse

1927(g)(2)(A)(ii)  
42 CFR 456.705(c)  
and (d)

3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g)(2)(B)  
42 CFR 456.709(a)

- F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

\* The State's RetroDUR System will capture and perform retrospective DUR on any drug product not included in a nursing home's per diem rate.

TN #93-21

Approval Date September 13, 1993

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Effective Date April 1, 1993

**New York  
74b**

**Citation**

927(g)(2)(C)  
42 CFR 456.709(b)

- F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:
- Therapeutic appropriateness
  - Overutilization and underutilization
  - Appropriate use of generic products
  - Therapeutic duplication
  - Drug-disease contraindications
  - Drug-drug interactions
  - Incorrect drug dosage/duration of drug treatment
  - Clinical abuse/misuse

1927(g)(2)(D)  
42 CFR 456.711

3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

1927(g)(3)(A)  
42 CFR 456.716(a)

- G.1. The DUR program has established a State DUR Board either:
- Directly, or  
 Under contract with a private organization

1927(g)(3)(B)  
42 CFR 456.716  
(A) AND (B)

2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:
- Clinically appropriate prescribing of covered outpatient drugs
  - Clinically appropriate dispensing and monitoring of covered outpatient drugs
  - Drug use review, evaluation and intervention
  - Medical quality assurance.

927(g)(3)(C)  
42 CFR 456.716(d)

- F.1. The activities of the DUR Board include:
- Retrospective DUR,
  - Application of Standards as defined in section 1927(g)(2)(C), and
  - Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

TN #93-21

Approval Date September 13, 1993

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Effective Date April 1, 1993

**New York  
74c**

**Citation**

1927(g)(3)(C)  
42 CFR 456.711  
(a)-(d)

- G.4. The interventions include in appropriate instances:
- Information dissemination
  - Written, oral, and electronic reminders
  - Face-to-Face discussions
  - Intensified monitoring/review of prescribers/dispensers

1927(g)(3)(D)  
42 CFR 456.712  
(A) and (B)

- H. The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.

1927(h)(1)  
42 CFR 456.722

- \_\_\_ I.1. The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line:
- real time eligibility verification
  - claims data capture
  - adjudication of claims
  - assistance to pharmacists, etc. applying for and receiving payment.

1927(g)(2)(A)(i)  
42 CFR 456.705(b)

- \_\_\_ 2. Prospective DUR is performed using an electronic point of sale drug claims processing system.

1927(j)(2)  
42 CFR 456.703(c)

- J. Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

TN #93-21

Supersedes TN NEW

Approval Date September 13, 1993

Effective Date April 1, 1993

**New York  
74d**

1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)

**K. Claim Review Limitations**

- Prospective safety edits on opioid prescriptions to address days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness.
- Prospective safety edits on maximum daily morphine milligram equivalents (MME) on opioids prescriptions to limit the daily morphine milligram equivalent (as recommended by clinical guidelines).
- Retrospective reviews on opioid prescriptions exceeding these above limitations on an ongoing basis.
- Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis.

**Programs to monitor antipsychotic medications to children:** Antipsychotic agents are reviewed for appropriateness for all children including foster children based on approved indications and clinical guidelines.

**Fraud and abuse identification:** The DUR program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.

TN #19-0053  
Supersedes TN NEW

Approval Date February 6, 2020  
Effective Date October 1, 2019

New York  
75

**Citation**

42 CFR 431.115(c)

AT-78-90

AT-79-74

**4.27 Disclosure of Survey Information and Provider  
or Contractor Evaluation**

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

TN #83-33

Supersedes TN #76-59

Approval Date January 12, 1984

Effective Date October 1, 1983

New York  
76

**Citation**

42 CFR 431.152;  
AT-79-18  
52 FR 22444;  
Secs.  
1902(a)(28)(D)(i)  
and 1919(e)(7) of  
the Act; P.L.  
100-203 (Sec. 4211(c))

**4.28 Appeals Process**

- (a) The Medicaid agency has established appeals procedures for NFs and specified in 42 CFR 431.153 and 431.154.
- (b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

TN #93-14

Supersedes TN #89-43

Approval Date June 28, 1993

Effective Date January 1, 1993

New York  
77

**Citation**

1902(a)(4)(C) of the  
Social Security Act  
P.L. 105-33

1902(a)(4)(D) of the  
Social Security Act  
P.L. 105-33

**4.29 Conflict of Interest Provisions**

The Medicaid agency meets the requirements of section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.

The Medicaid agency meets the requirements of section 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

TN #99-30

Supersedes TN #86-26

Approval Date December 6, 1999

Effective Date July 1, 1999

New York  
78

**Citation**

42 CFR 1002.203  
AT-79-54  
48 FR 3742  
51 FR 34772

**4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals**

- (a) All requirements of 42 CFR Part 1002, Subpart B are met.
- [X] The agency, under the authority of State law, imposes broader sanctions.

TN #88-7

Supersedes TN #83-34

Approval Date January 13, 1992

Effective Date January 1, 1988

**New York**  
**78a**

**Citation**

1902(p) of the Act  
P.L. 100-93  
(secs. 7)

- (b) The Medicaid agency meets the requirements of --
  - (1) Section 1902(p) of the Act by excluding from participation --
    - (A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with section 1128, 1128A, or 1866(b)(2).
    - (B) Any HMO (as defined in section 1903(m) of the Act) or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that --
      - (i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
      - (ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

TN   #88-7    
Supersedes TN   NEW  

Approval Date   January 13, 1992    
Effective Date   January 1, 1988

New York  
78b

**Citation**

1902(a)(39) of the Act  
P.L. 100-93  
(sec. 8(f))

(2) Section 1902(a)(39) of the Act by –

(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with section 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of --

1902(a)(41)  
of the Act  
P.L. 96-272  
(sec. 308(c))

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act  
P.L. 100-93  
(sec. 5(a)(4))

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

TN #88-7

Approval Date January 13, 1992

Supersedes TN NEW

Effective Date January 1, 1988

New York  
79

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**4.31 Disclosure of Information by Providers and Fiscal Agents**

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

**4.32 Income and Eligibility Verification System**

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (Section 1137 of the Act and 42 CFR 435.940 through 435.960).

(b) [ATTACHMENT 4.32-A](#) describes in accordance with 42 CFR 435.948(a)(6) the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

TN #10-24

Approval Date December 2, 2010

Supersedes TN #88-7

Effective Date July 1, 2010

New York  
79a

**Citation**

1902(a)(48)  
of the Act,  
P.L. 99-570  
(Section 11005)  
P.L. 100-93  
(sec. 5(a)(3))

**4.33 Medicaid Eligibility Cards for Homeless Individuals**

- (a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.
- (b) [ATTACHMENT 4.33-A](#) specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

TN #88-7

Supersedes TN #87-35A

Approval Date January 13, 1992

Effective Date January 1, 1988

New York  
79c

Citation

**4.35 Remedies for Nursing Facilities that Do Not Meet Requirements of Participation**

1919(h)(1) and (2) of the Act, P.L. 100-203 (Sec. 4213(a))

(a) The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for nursing facilities that do not meet one or more requirements of participation. [ATTACHMENT 4.35-A](#) describes the criteria for applying the remedies specified in section 1919(h)(2)(A)(i) through (iv) of the Act.

- [X] (b) The agency uses the following remedy(ies):
- 1) Denial of payment of new admissions (Direct)
  - 2) Civil money penalty (Alternative)
  - 3) Appointment of temporary management (Alternative)
  - 4) In emergency cases, closure of the facility and/or transfer of residents (Direct)

1919(h)(2)(B)(ii) of the Act

[X] (c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). [ATTACHMENT 4.35-B](#) describes these alternative remedies and specifies the basis for their use.

1919(h)(2)(F) of the Act

[X] (d) The agency uses one of the following incentive programs to reward nursing facilities that furnish the highest quality care to Medicaid residents:

- [X] 1) Public recognition.
- [ ] 2) Incentive payments.

TN #90-19

Approval Date January 26, 1995

Supersedes TN NEW

Effective Date April 1, 1990

**New York**  
**79c.1**

**Citation****4.35 Enforcement of Compliance for Nursing Facilities**

42 CFR  
§488.402(f)

**(a) Notification of Enforcement Remedies**

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

- (1) nature of noncompliance,
- (2) which remedy is imposed,
- (3) effective date of the remedy, and
- (4) right to appeal the determination leading to the remedy.

42 CFR  
§488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR  
§488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR  
§488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

**(b) Factors to be Considered in Selecting Remedies**

42 CFR  
§488.488.404(b)(1)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

\_\_\_ The State considers additional factors. [Attachment 4.35-A](#) describes the State's other factors.

TN   #95-33  

Approval Date   March 7, 1997  

Supersedes TN   NEW  

Effective Date   July 1, 1995

**New York  
79c.2**

**Citation**

42 CFR  
§488.410

42 CFR  
§488.417(b)  
§1919(h)(2)(C)  
of the Act.

42 CFR  
§488.414  
§1919(h)(2)(D)  
of the Act.

42 CFR  
§488.408  
1919(h)(2)(A)  
of the Act.

42 CFR  
§488.412(a)

**(c) Application of Remedies**

- (i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.
- (ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.
- (iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.
- (iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.
- (v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

**(d) Available Remedies**

42 CFR  
§488.406(b)  
§1919(h)(2)(A)  
of the Act.

- (i) The State has established the remedies defined in 42 CFR 488.406(b).
  - (1) Termination
  - (2) Temporary Management
  - (3) Denial of Payment for New Admissions
  - (4) Civil Money Penalties
  - (5) Transfer of Residents; Transfer of Residents with Closure of Facility
  - (6) State Monitoring
  - (7) Directed Plan of Correction
  - (8) Directed Inservice Training

Attachments 4.35-B through 4.35-J describe the criteria for applying the above remedies.

TN #95-33

Supersedes TN NEW

Approval Date March 7, 1997

Effective Date July 1, 1995

New York  
79c.3

**Citation**

42 CFR  
§488.406(b)  
§1919(h)(2)(B)(ii)  
of the Act.

(ii)  X  The State uses alternative remedies.  
The State has established alternative  
remedies that the State will impose in  
place of a remedy specified in 42 CFR  
488.406(b).

- X  (1) Temporary Management
- (2) Denial of Payment for New Admissions
- (3) Civil Money Penalties
- (4) Transfer of Residents; Transfer of  
Residents with Closure of Facility
- (5) State Monitoring

Attachments 4.35-B through 4.35-G describe the  
alternative remedies and the criteria for applying them.

42 CFR  
§488.303(b)  
1910(h)(2)(F)  
of the Act.

(e)  X  **State Incentive Programs**

- X  (1) Public Recognition
- X  (2) Incentive Payments

TN  #95-33   
Supersedes TN  NEW

Approval Date  March 7, 1997   
Effective Date  July 1, 1995

New York  
79d

Citation

1902(a)(11)(C)  
and 1902(a)(53)  
of the Act

4.36 Required Coordination Between the Medicaid and WIC Programs

The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

TN #91-75

Supersedes TN NEW

Approval Date March 3, 1992

Effective Date October 1, 1991

**New York  
79n**

**Citation**

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 102-508 (Sec. 4801(a)).

**4.38 Nurse Aid Training and Competency Evaluation for Nursing Facilities**

- (a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
- (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).
- (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.
- (d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
- (e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
- (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

TN #92-05

Supersedes TN NEW

Approval Date April 29, 1992

Effective Date January 1, 1992

**New York**  
**79o**

**Citation**

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

- (g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluations programs and competency evaluation programs upon request.
- (h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
- (i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
- (j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.
- (k) For program reviews other than the initial review, the State visits the entity providing the program.
- (l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

TN   #92-05  

Supersedes TN   NEW  

Approval Date   April 29, 1992  

Effective Date   January 1, 1992

**New York**  
**79p**

**Citation**

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

- (m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
- (n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
- (o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
- (p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) and (3).
- X (q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
- (r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

TN     #92-05    

Supersedes TN     NEW    

Approval Date     April 29, 1992    

Effective Date     January 1, 1992

**New York  
79q**

**Citation**

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

- (s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing indicating the reasons for withdrawal of approval.
- (t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
- (u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
- (v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
- (w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
- (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
- (y) The State has a standard for successful completion of competency evaluation programs.

TN   #92-05  

Supersedes TN   NEW  

Approval Date   April 29, 1992  

Effective Date   January 1, 1992

**New York**  
**79r**

**Citation**

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

- (z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
- (aa) The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
- (bb) The State maintains a nurse aide registry that meets the requirements of 42 CFR 483.156.
- (cc) The State includes home health aides on the registry.
- (dd) The State contracts the operation of the registry to a non State entity.
- (ee) [ATTACHMENT 4.38](#) contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
- (ff) [ATTACHMENT 4.38-A](#) contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

TN #92-05Supersedes TN NEWApproval Date April 29, 1992Effective Date January 1, 1992

New York  
79s

**Citation**

Secs.  
1902(a)(28)(D)(i)  
and 1919(e)(7) of  
the Act;  
P.L. 100-203  
(Sec. 4211(c));  
P.L. 101-508  
(Sec. 4801(b)).

**4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities**

- (a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).
- (b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.
- (c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.
- (d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.
- (e) [ATTACHMENT 4.39](#) specifies the State's definition of specialized services.

TN #93-14  
Supersedes TN NEW

Approval Date June 28, 1993  
Effective Date January 1, 1993

New York  
79t

4.39 (Continued)

- (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.
  
- (g) The State describes any categorical determinations it applies in [ATTACHMENT 4.39-A](#).

TN #93-14

Approval Date June 28, 1993

Supersedes TN NEW

Effective Date January 1, 1993

**New York  
79u**

**Citation**

Sections  
1919(g)(1)  
thru (2) and  
1919(g)(4)  
thru (5) of  
the Act P.L.  
100-203  
(Sec.  
4212(a))

1919(g)(1)  
(B) of the  
Act

1919(g)(1)  
(C) of the  
Act

**4.40 Survey & Certification Process**

- (a) The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.
- (b) The State conducts periodic education programs for staff and residents (and their representatives). [Attachment 4.40-A](#) describes the survey and certification educational program.
- (c) The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. [Attachment 4.40-B](#) describes the State's process.
- (d) The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency?
- 
- (e) The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
- (f) The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

TN #92-37

Supersedes TN NEW

Approval Date January 31, 1995

Effective Date April 1, 1992

**New York  
79v**

- |                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1919(g)(2)<br>(A)(i) of<br>the Act       | (g) The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. <a href="#">Attachment 4.40-C</a> describes the State's procedures.                                                                                                                                                                                                                        |
| 1919(g)(2)<br>(A)(ii) of<br>the Act      | (h) The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey. |
| 1919(g)(2)<br>(A)(iii)(I)<br>of the Act  | (i) The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 1919(g)(2)<br>(A)(iii)(II)<br>of the Act | (j) The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.                                                                                                                                                                                                                                                             |
| 1919(g)(2)<br>(B) of the<br>Act          | (k) The State conducts extended surveys immediately or, if not practicable, not later than 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.                                                                                                                                                                                                                                                                                                   |
| 1919(g)(2)<br>(C) of the<br>Act          | (l) The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.                                                                                                                                                                                                                                                                                                                             |

TN   #92-37  

Supersedes TN   NEW  

Approval Date   January 31, 1995  

Effective Date   April 1, 1992

**New York  
79w**

- |                                      |                                                                                                                                                                                                                                                                                            |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1919(g)(2)<br>(D) of the<br>Act      | (m) The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. <a href="#">Attachment 4.40-D</a> describes the State's programs.                                                                                            |
| 1919(g)(2)<br>(E)(i) of<br>the Act   | (n) The State uses a multidisciplinary team of professionals including a registered professional nurse.                                                                                                                                                                                    |
| 1919(g)(2)<br>(E)(ii) of<br>the Act  | (o) The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.                       |
| 1919(g)(2)<br>(E)(iii) of<br>the Act | (p) The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.                                                         |
| 1919(g)(4)<br>of the Act             | (q) The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. <a href="#">Attachment 4.40-E</a> describes the State's complaint procedures.                                                   |
| 1919(g)(5)<br>(A) of the<br>Act      | (r) The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act. |
| 1919(g)(5)<br>(B) of the<br>Act      | (s) The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.                                                                |
| 1919(g)(5)<br>(C) of the<br>Act      | (t) If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.                                                           |
| 1919(g)(5)<br>(D) of the<br>Act      | (u) The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.                                                                                                                                                    |

TN   #92-37  

Supersedes TN   NEW  

Approval Date   January 31, 1995  

Effective Date   April 1, 1992

New York  
79x

**Citation**

**4.41 Resident Assessment for Nursing Facilities**

Sections  
1919(b)(3)  
and 1919  
(e)(5) of  
the Act

(a) The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.

1919(e)(5)  
(A) of the  
Act

(b) The State is using:  
  
\_\_\_\_\_ the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or

1919(e)(5)  
(B) of the  
Act

X a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

TN #92-23

Approval Date July 30, 1992

Supersedes TN NEW

Effective Date April 1, 1992

New York  
79y

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Citation

1902(a)(69) of  
the Act,  
P.L. 109-171  
(section 6034)

4.43 Cooperation with Medicaid Integrity Program Efforts.

The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under Section 1936 of the Act.

TN #08-59

Approval Date July 29, 2008

Supersedes TN NEW

Effective Date April 1, 2008

New York  
79-z

**4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States**

**Citation: Section 1902(a)(80) of Social Security Act, P.L. 111-148 (Section 6505)**

**[X] The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.**

TN #11-78

Approval Date June 1, 2011

Supersedes TN NEW

Effective Date July 6, 2011

New York  
79(aa)

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**4.46 Provider Screening and Enrollment****Citation**

1902(a)(77)  
1902(a)(39)  
1902(kk);  
P.L. 111-148 and  
P.L. 111-152

The State Medicaid agency gives the following assurances:

42 CFR 455

Subpart E

**PROVIDER SCREENING**

X Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.

42 CFR 455.410

**ENROLLMENT AND SCREENING OF PROVIDERS**

X Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.

X Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.

42 CFR 455.412

**VERIFICATION OF PROVIDER LICENSES**

X Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.

42 CFR 455.414

**REVALIDATION OF ENROLLMENT**

X Assures that providers will be revalidated regardless of provider type at least every 5 years.

42 CFR 455.416

**TERMINATION OR DENIAL OF ENROLLMENT**

X Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

42 CFR 455.420

**REACTIVATION OF PROVIDER ENROLLMENT**

X Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

TN #12-07

Supersedes TN NEW

Approval Date July 16, 2013

Effective Date April 1, 2013

New York  
79(ab)**4.46 Provider Screening and Enrollment** (Continued)42 CFR 455.422**APPEAL RIGHTS**X Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.42 CFR 455.432**SITE VISITS**X Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.42 CFR 455.434**CRIMINAL BACKGROUND CHECKS**X Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.42 CFR 455.436**FEDERAL DATABASE CHECKS**X Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agency or managing employee of the provider.42 CFR 455.440**NATIONAL PROVIDER IDENTIFIER**X Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.42 CFR 455.450**SCREENING LEVELS FOR MEDICAID PROVIDERS**X Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.TN #12-07Approval Date July 16, 2013Supersedes TN NEWEffective Date April 1, 2013

New York  
79(ac)

**4.46 Provider Screening and Enrollment** (Continued)

42 CFR 455.460

**APPLICATION FEE**

X Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

42 CFR 455.470

**TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS**

X Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

TN #12-07

Approval Date July 16, 2013

Supersedes TN NEW

Effective Date April 1, 2013

New York  
80

SECTION 5 PERSONNEL ADMINISTRATION

**Citation**

42 CFR 432.10(a)  
AT-78-90  
AT-78-23  
AT-80-34

**5.1 Standards of Personnel Administration**

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

[X] The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) **Affirmative Action Plan**

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

TN   #77-37  

Supersedes TN   #76-10  

Approval Date   December 28, 1977  

Effective Date   September 28, 1977

New York  
81

5.2 [Reserved]

TN \_\_\_\_\_

Approval Date \_\_\_\_\_

Supersedes TN \_\_\_\_\_

Effective Date \_\_\_\_\_

New York  
82

**Citation**

42 CFR Part 432,  
Subpart B  
AT-78-90

**5.3 Training Programs; Subprofessional and  
Volunteer Programs**

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

TN       #78-1      

Supersedes TN       #77-37      

Approval Date       April 3, 1978      

Effective Date       February 27, 1978

New York  
83

**SECTION 6 FINANCIAL ADMINISTRATION**

**Citation**

42 CFR 433.32  
AT-79-29

**6.1 Fiscal Policies and Accountability**

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

TN       #74-2      

Supersedes TN       None      

Approval Date       December 31, 1974      

Effective Date       Prior to January 1, 1974



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85

**Citation**

42 CFR 433.33  
AT-79-29  
AT-80-34

**6.3 State Financial Participation**

- (a) State funds are used in both assistance and administration.
  - [ ] State funds are used to pay all of the non-Federal share of total expenditures under the plan.
  - [X] There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.
- (b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

\* For 6.3(b):

TN #77-41  
Supersedes TN #74-2

Approval Date: March 13, 1978  
Effective Date: October 1, 1977

TN       #74-2        
Supersedes TN   None  

Approval Date   December 31, 1974    
Effective Date   Prior to January 1, 1974

New York  
86

SECTION 7 GENERAL PROVISIONS

Citation

42 CFR 430.12(c)

7.1 Plan Amendments

The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

TN           #91-75          

Supersedes TN   #74-2  

Approval Date           March 3, 1992          

Effective Date           October 1, 1991

New York  
87

**Citation**

45 CFR Parts  
80 and 84

**7.2 Nondiscrimination**

In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in [ATTACHMENT 7.2-A](#).

TN           #91-75          

Supersedes TN   #79-11  

Approval Date           November 4, 1996          

Effective Date           October 1, 1996

New York  
88

**Citation**

1902(c) of  
the Act

**7.3 Maintenance of AFDC Efforts**

- [X] The State agency has in effect under its approved AFDC plan payment levels that are equal to or more than the AFDC payment levels in effect on May 1, 1988.

TN           #91-76          

Supersedes TN   New  

Approval Date           March 3, 1992          

Effective Date           October 1, 1991

New York  
89

**Citation**

42 CFR 430.12(b)

**7.4 State Governor's Review**

The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

- Not applicable. The Governor --
- Does not wish to review any plan material.
- Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

\_\_\_\_\_  
New York State Department of Health  
(Designated Single State Agency)

Date: September 6, 1996

\_\_\_\_\_  
/s/ Barbara A. DeBuono, MD  
(Signature)

\_\_\_\_\_  
Commissioner  
(Title)

TN #96-33

Approval Date November 4, 1996

Supersedes TN #91-75

Effective Date October 1, 1996