

New York

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**[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY  
DETERMINATION]**

Agency *	Citation(s)	Groups Covered
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The following groups are covered under this plan.

**A. Mandatory Coverage – Categorically Needy and Other  
Required Special Groups**

42 CFR 435.110

**1. Recipients of AFDC**

The approved State AFDC plan includes:

- [X] Families with an unemployed parent for the mandatory 6-month period and an optional extension of 6 months
- [X] Pregnant women with no other eligible children.
- [X] AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of [ATTACHMENT 2.6-A](#).

42 CFR 435.115

**2. Deemed Recipients of AFDC**

- a. Individuals denied a title IV-A cash payment solely because the amount would be less than \$10.

\* Agency that determines eligibility for coverage.]

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## New York

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Agency *	Citation(s)	Groups Covered
<b>A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</b>		
[408(a)(11)(B) and/or 1931(c)(1); 42 CFR 435.115; and 1902(a)(10)(A)(i)(I) of the Act	b.	An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support [and meets the requirements of section 406(h) of the Act].
42 CFR 435.115(e) and 42 CFR 435.145 1902(a)(10)(A)(i)(I), 473(b)(1), and 473(b)(3) of the Act	c.	Title IV-E Subsidized Adoption, Foster Care, or Kinship Guardianship Assistance for Children. Individuals who meet the requirements of section 473(b) of the Act for whom an adoption assistance agreement is in effect or foster care maintenance or kinship guardianship assistance payments are made under title IV-E of the Act.]

\* Agency that determines eligibility for coverage.

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**New York**  
**2a**

Agency *	Citation(s)	Groups Covered
<b>A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</b>		
[407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act]	<b>[3. Qualified Family Members</b>	
	Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.	
	[X] Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.]	
1902(a)(52) and 1925 of the Act	3. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)	

\* Agency that determines eligibility for coverage

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## New York

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[Agency *	Citation(s)	Groups Covered
<b>A. Mandatory Coverage – Categorically Needy and Other Required Special Groups</b>		
42 CFR 435.113	<p>5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:</p> <ul style="list-style-type: none"> <li>a. Families denied AFDC solely because of income and resources deemed to be available from – – <ul style="list-style-type: none"> <li>(1) Stepparents who are not legally liable for support of stepchildren under a state law of general applicability;</li> <li>(2) Grandparents;</li> <li>(3) Legal guardians; and</li> <li>(4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);</li> </ul> </li> <li>b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.</li> <li>c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.</li> </ul>	

\* Agency that determines eligibility for coverage.]

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**New York**  
**3a**

[Agency *	Citation(s)	Groups Covered
<b>A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</b>		
42 CFR 435.114	<p>6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.</p>	<p>[X] Includes persons who would have been eligible cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).</p> <p>[X] Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).</p> <p>[ ] Not applicable with respect to intermediate care facilities; State did or does not cover this service.</p>
1902(a)(10) (A)(i)(III) and 1905(n) of the Act	<b>7. Qualified Pregnant Women and Children.</b>	<p>a. A pregnant woman whose pregnancy has been medically verified who --</p> <p>(1) Would be eligible for an AFDC cash payment (or who would be eligible if the State had an AFDC-unemployed parents program) if the child had been born and was living with her;</p>

\* Agency that determines eligibility for coverage.]

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## New York

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

## COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
1902(a)(10)(A) (i)(III) and 1905(n) of the Act	<b>A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</b>
	<p>7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or</p> <p>(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.</p>
	<p>b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.</p>
	<p>_____ Children born after _____ (specify optional earlier date) who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.]</p>

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**New York**  
**4a**

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

**COVERAGE AND CONDITIONS OF ELIGIBILITY**

**Citations(s)**

**Groups Covered**

**A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)**

1902(a)(10)(A)  
(I)(IV) and  
1902(1)(1)(A)  
and (B) of the Act

8. Pregnant women and infants under 1 year of age with family income up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(I)(IV) and 1902(1)(1)(A) and (B) of the Act. The income level for this group is specified in [Supplement 1 to ATTACHMENT 2.6-A](#).

  X   The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.

**9. Children**

1902(a)(10)(A)  
(I)(VI)  
1902(1)(1)(c)  
of the Act

- a. who have attained 1 year of age but have and not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.

1902(a)(10)(A)(I)  
(VII) and 1902(1)  
(1)(D) of the Act

- b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

  X   Children born after   12/31/79    
(specify optional earlier date)  
who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Income levels for those groups are specified in [Supplement 1 to ATTACHMENT 2.6A](#).]

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## New York

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

## COVERAGE AND CONDITIONS OF ELIGIBILITY

Citations(s)	Groups Covered
<b>A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</b>	
[1902(a)(10)(A)(i)(V) and 1905(m) of the Act]	[10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.]
1902(3)(5) of the Act	11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

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New York  
6

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
COVERAGE AND CONDITIONS OF ELIGIBILITY

Citations(s)	Groups Covered
	<p><b>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u></b></p>
1902(e)(4) of the Act	<p>12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.</p>
42 CFR 435.120	<p><b>13. Aged, Blind and Disabled Individuals Receiving Cash Assistance</b></p> <p><u>  X  </u> a. Individuals receiving SSI.</p> <p style="padding-left: 40px;">This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.</p> <p style="padding-left: 40px;"><u>  X  </u> Aged <u>  X  </u> Blind <u>  X  </u> Disabled</p>

TN   #92-27  Approval Date   January 20, 1993  Supersedes TN   #91-76  Effective Date   April 1, 1992

**New York  
6a**

Agency *	Citation(s)	Groups Covered
<b>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u></b>		
435.121  1619(b)(1) of the Act	13. [ ] b.	<p>Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619 (a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(a)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)</p> <p> <input type="checkbox"/> Aged  <input type="checkbox"/> Blind  <input type="checkbox"/> Disabled         </p> <p>The more restrictive categorical eligibility criteria are described below:</p>

(Financial criteria are described in  
[ATTACHMENT 2.6-A](#))

\* Agency that determines eligibility for coverage.

TN #91-76

Approval Date March 3, 1992

Supersedes TN #87-35A

Effective Date October 1, 1991

**New York  
6b**

Agency *	Citation(s)	Groups Covered
<b>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u></b>		
1902(a) (10)(A) (i)(II) and 1905 (q) of the Act	14.	<p>Qualified severely impaired blind and disabled individuals under age 65, who --</p> <p>a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or</p> <p>b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must --</p> <p>(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;</p> <p>(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;</p> <p>(3) Have unearned income amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;</p>

\* Agency that determines eligibility for coverage.

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Effective Date October 1, 1991

New York  
6c

Agency *	Citation(s)	Groups Covered
<p style="text-align: center;"><b>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u></b></p>		
		<p>(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and</p>
		<p>(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.</p>
		<p>[ ] Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.</p>

\* Agency that determine eligibility for coverage.

TN #91-76

Approval Date March 3, 1992

Supersedes TN #87-35A

Effective Date October 1, 1991

**New York  
6d**

Agency *	Citation(s)	Groups Covered
	<b>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u></b>	
1619(b)(3) of the Act	[ ] The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.	

\*\* Agency that determines eligibility for coverage.

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**New York**  
**6e**

Agency *	Citation(s)	Groups Covered
<b>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u></b>		
1634(c) of the Act	<p>15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who –</p> <ul style="list-style-type: none"> <li>a. Are at least 18 years of age;</li> <li>b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.</li> <li>[ ] c. The State applies more restrictive eligibility requirements than those under SSI, and part of all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.</li> <li>[ ] d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.</li> </ul>	
42 CFR 435.122	16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.	
45 CFR 435.130	17. Individuals receiving mandatory State supplements.	

\* Agency that determines eligibility for coverage.

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New York  
6f

Agency *	Citation(s)	Groups Covered
<p style="text-align: center;"><b>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u></b></p>		
45 CFR 435.131	<p>18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.</p> <p>[X] In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):</p> <p style="padding-left: 40px;"><u>  X  </u> Aged    <u>  X  </u> Blind    <u>  X  </u> Disabled</p> <p>[ ] Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.</p>	

\* Agency that determines eligibility for coverage.

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New York  
6g

Agency *	Citation(s)	Groups Covered
<b>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u></b>		
42 CFR 435.132	19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they – –  a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and  b. Remain institutionalized; and  c. Continue to need institutional care.	
42 CFR 435.133	20. Blind and disabled individuals who – –  a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and  b. Were eligible for Medicaid in December 1973 as blind or disabled; and  c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.	

\* Agency that determines eligibility for coverage.

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## New York

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Agency *	Citation(s)	Groups Covered
<p><b>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u></b></p>		
42 CFR 435.134	<p>21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.</p>	<p>[X] Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).</p> <p>[X] Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).</p> <p>[ ] Not applicable with respect to intermediate care facilities; the State did or does not cover this service.</p>

\* Agency that determines eligibility for coverage.

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## New York

8

Agency *	Citation(s)	Groups Covered
<p data-bbox="548 449 1409 522"><b>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u></b></p>		
42 CFR 435.135	22. Individuals who --	<p data-bbox="691 627 1393 732">a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and</p> <p data-bbox="691 764 1344 974">b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.</p> <p data-bbox="764 1016 1393 1152">[ ] Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.</p> <p data-bbox="764 1184 1354 1289">[ ] Not applicable because the State applies more restrictive eligibility requirements than those under SSI.</p> <p data-bbox="764 1331 1425 1575">[ ] The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.</p>

\* Agency that determines eligibility for coverage.

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## New York

9

Agency *	Citation(s)	Groups Covered
<p><b>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u></b></p>		
1634 of the Act	<p>23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for the purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634 (b) of the Act.</p> <p>[ ] Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.</p> <p>[ ] The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have the income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.</p>	

\* Agency that determines eligibility for coverage.

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Supersedes TN <u>#86-29A</u>	Effective Date <u>October 1, 1991</u>

**New York**  
**9a**

Agency *	Citation(s)	Groups Covered
<b>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u></b>		
1634(d) of the Act	24. Disabled widows and widowers who would be eligible for SSI except for receipt of early social security disability benefits, who are not entitled to hospital insurance under Medicare Part A and who are deemed, for the purposes of title XIX, to be SSI beneficiaries under section 1634(d) of the Act.	<p data-bbox="691 840 1325 978">[ ] Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.</p> <p data-bbox="691 1016 1373 1188">[ ] Not applicable because the State applies more restrictive eligibility than those under SSI and the State chooses not to deduct any of the benefit that caused SSI/SSP ineligibility or subsequent cost-of-living increases.</p> <p data-bbox="691 1226 1373 1470">[ ] The State applies more restrictive eligibility requirements than those under SSI and part or all of the amount of the benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of the countable income for categorically needy eligibility.</p>

\* Agency that determines eligibility for coverage.

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**New York**  
**9b**

Agency	Citation(s)	Groups Covered
<p style="text-align: center;"><b>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u></b></p>		
1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	<b>25. Qualified Medicare Beneficiaries --</b>	
	<ul style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);</li> <li>b. Whose income does not exceed 100 percent of the Federal Poverty Level; and</li> <li>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</li> </ul> <p>(Medical Assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)</p>	
1902(a)(10)(E)(ii), 1905(p)(3)(A)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act	<b>26. Qualified disabled and working individuals</b>	
	<ul style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Section 1818A of the Act;</li> <li>b. Whose income does not exceed 200 percent of the Federal poverty level</li> </ul>	

TN #10-15  
Supersedes TN #93-27

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**New York  
9b1**

<b>Agency</b>	<b>Citation(s)</b>	<b>Groups Covered</b>
		<ul style="list-style-type: none"> <li>c. Whose resources do not exceed twice the maximum standard under SSI.</li> <li>d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.</li> </ul> <p>(Medical assistance for this group is limited to Medicare part A premiums under section 1818A of the Act.)</p>
1902(a)(10)(E)(iii) 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) of the Act	<b>27. Specified Low-Income Medicare Beneficiaries --</b>	<ul style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Medicare part A (but not pursuant to an enrollment under 1818A of the Act.</li> <li>b. Whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and</li> <li>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</li> </ul> <p>(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)</p>
1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	<b>28. Qualified Individuals --</b>	<ul style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under 1818A of the Act);</li> <li>b. Whose income is at least 120 percent but less than 135 percent of the Federal poverty level;</li> <li>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</li> </ul>

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New York  
9b2

Agency *	Citation(s)	Groups Covered
<p style="text-align: center;"><b>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u></b></p>		
1634(e) of the Act	28. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of Section 1611(e)(3)(A) shall be treated, for purposes of title XIX, as receiving SSI benefits for the month.	

\* Agency that determines eligibility for coverage.

TN #95-15

Approval Date April 26, 1995

Supersedes TN NEW

Effective Date February 10, 1995

New York  
9c

Agency *	Citation(s)	Groups Covered
<b>B. Optional Groups Other Than the Medically Needy</b>		
42 CFR 435.210 1902(a) (10)(A)(ii) and 1905(a) of the Act	[X] 1.	<p>Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.</p> <p>[X] The plan covers all individuals as described above.</p> <p>[ ] The plan covers only the following group or groups of individuals:</p> <p> <input type="checkbox"/> Aged  <input type="checkbox"/> Blind  <input type="checkbox"/> Disabled  <input type="checkbox"/> Caretaker relatives  <input type="checkbox"/> Pregnant women] </p>
42 CFR 435.211	[X] 2.	Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

\* Agency that determines eligibility for coverage.

TN <u>#13-0053</u>	Approval Date <u>June 26, 2014</u>
Supersedes TN <u>#91-00</u>	Effective Date <u>January 1, 2014</u>



New York  
10

## Citation(s)

## Groups Covered

**B. Optional Groups – Other Than Medically Needy**  
**(Continued)**

42 CFR 435.212  
& 1902(e) of the Act,  
P.L. 99-272 (section 9517)  
P.L. 101-508 (section 4732)  
P.L. 105-33 (section 4708)

X

3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in a Medicaid managed care organization as defined in section 1903(m)(1)(A), with a primary care case manager as defined in section 1905(1), or with an eligible organization under section 1876 of the Act, and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (not more than six months beginning on the effective date of enrollment), the State Plan may provide, notwithstanding any other provision of this title that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum enrollment period, but, except for benefits furnished under section 1905(a)(4)(c), only with respect to such benefits provided to the individual as a enrollee of such organization or entity or by or through the case manager.

\_\_\_ The State elects not to guarantee eligibility

X The State elects to guarantee eligibility. The minimum enrollment period in 6 months (not to exceed six).

The State measures the minimum enrollment period from:

\_\_\_ The date beginning the period of enrollment in the MCO or other entity, without any intervening disenrollment, regardless of Medicaid eligibility.

X The date beginning the period of enrollment in the MCO as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

\_\_\_ The date beginning the last period of enrollment in the MCO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment or of periods of enrollment as a private paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section.

TN #99-18

Approval Date February 10, 2000

Supersedes TN #92-09

Effective Date April 1, 1999

**New York  
10a**

Citation(s)	Groups Covered
<b>B. <u>Optional Groups – Other Than Medically Needy</u> (Continued)</b>	
1932 of the Act P.L. 98-369 (section 2364), P.L. 99-272 (section 9517), P.L. 101-508 (section 4732), P.L. 105-33 (section 4701)	<p>The Medicaid Agency may elect to restrict the disenrollment rights of Medicaid enrollees of a managed care entity as defined in section 1932 of the Act. The requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.</p> <p><u>  X  </u> Disenrollment rights are restricted for a period of <u>12</u> months (not to exceed 12 months).</p> <p>During the first ninety (90) days of the first twelve month restricted period and after the first twelve months the recipient may disenroll without cause. The State will provide notification at least sixty (60) days before the end of each enrollment period, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.</p> <p><u>      </u> No restrictions upon disenrollment rights.</p>
1903(m)(2)(H), 1902(a)(52) of the Act P.L. 101-508 (section 4732), P.L. 105-33 (section 4702(b)(1)(A))	<p>In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an entity having a contract under section 1903(m) when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.</p> <p><u>  X  </u> The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible into the same entity in which they enrolled at the time eligibility was lost.</p> <p><u>      </u> The agency elects not to reenroll the above individuals into the same entity in which they were previously enrolled.</p>

TN   #99-18    
Supersedes TN   #92-09  

Approval Date   February 10, 2000    
Effective Date   April 1, 1999

New York  
11

**B. Optional Groups Other Than the Medically Needy**  
**(continued)**

Citation        42 CFR 435.217

  X   4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver.\* The group or groups covered are listed in waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

**\*This group of individuals includes PACE enrollees, and will be effective on the effective date of the amendment electing PACE as a State service.**

TN   #02-01  

Supersedes TN   #92-09  

Approval Date   September 03, 2002  

Effective Date   January 01, 2002

New York  
11a

Citation(s)	Groups Covered
1902(a)(10) (A)(ii)(VII) of the Act	<p data-bbox="548 453 1305 520"><b>B. <u>Optional Groups – Other Than Medically Needy</u></b> <b>(Continued)</b></p> <p data-bbox="548 558 1338 768">[ ] 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.</p> <p data-bbox="695 806 1198 873">[ ] The State covers all individuals as described above.</p> <p data-bbox="695 911 1338 978">[ ] The State covers only the following group or groups of individuals:</p> <div data-bbox="760 1016 1256 1365"> <p>___ Aged</p> <p>___ Blind</p> <p>___ Disabled</p> <p>___ Individuals under the age of --</p> <div data-bbox="857 1159 964 1293"> <p>___ 21</p> <p>___ 20</p> <p>___ 19</p> <p>___ 18</p> </div> <p>___ Caretaker relatives</p> <p>___ Pregnant women</p> </div>

TN #91-77Approval Date March 11, 1992Supersedes TN NEWEffective Date October 1, 1991

**New York**  
**12**

[Citation(s)]	Groups Covered
	<b>B. Optional Groups – Other Than Medically Needy (Continued)</b>
42 CFR 435.220	<p>[X] 6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.</p> <p>[X] The State covers all individuals as described above.</p>
1902(a)(10)(A)(ii) and 1905(a) of the Act	<p>[ ] The State covers only the following group or groups of individuals:</p> <p>___ Individuals under the age of – –</p> <p>___ 21</p> <p>___ 20</p> <p>___ 19</p> <p>___ 18</p> <p>___ Caretaker relatives</p> <p>___ Pregnant women</p>
42 CFR 435.2 1902(a)(10)(A)(ii) and 1905(a)(i) of the Act	<p>7. [X] a. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are 21 years of age or younger as indicated below.</p> <p>___ 20</p> <p>___ 19</p> <p>___ 18]</p>

TN #13-0053Approval Date June 26, 2014Supersedes TN #91-0077Effective Date January 1, 2014

**New York**  
**13**

[Agency]	Citation(s)	Groups Covered
<b>B. Optional Groups – Other Than Medically Needy (Continued)</b>		
42 CFR 435.222	[X] b. Reasonable classifications of individuals described in (a) above, as follows:	
	<u>  X  </u> (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:	
	___ (a) In foster homes (and are under the age of 21).	
	___ (b) In private institutions (and are under the age of 21).	
	___ (c) In addition to the group under b. (1) (a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___).	
	<u>  X  </u> (d) Children under the age of 21 for whom guardianship assistance payments are made and individuals in the care and custody of the local social services district commissioner or who are in the care and custody of the Office of Children and Family [s]Services for the purpose of receiving foster care (and are under the age of 21).	
	___ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ___).	
	___ (3) Individuals in NFs (who are under the age of ___). NF services are provided under this plan.	
	___ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ___).]	

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New York  
13a

[Agency *]	Citation(s)	Groups Covered
<p><b>B. Optional Groups – Other Than Medically Needy (Continued)</b></p>		
	— (5)	Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.
	— (6)	Other defined groups (and ages), as specified in <a href="#">Supplement 1 of Attachment 2.2-A.</a> ]

TN #13-0053Approval Date June 26, 2014Supersedes TN #91-0077Effective Date January 1, 2014

New York  
14

[Agency *	Citation(s)	Groups Covered
<p style="text-align: center;"><b>B. Optional Groups – Other Than Medically Needy (Continued)</b></p>		
1902(a)(10) (A)(ii)(VIII) of the Act	[X] 8.	<p>A child for whom there is in effect a state adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement --</p> <p>a. Was eligible for Medicaid under the State's approved Medicaid plan; or</p> <p>b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.</p>
The State covers individuals under the age of --		
		<u>  X  </u> 21 <u>     </u> 20 <u>     </u> 19 <u>     </u> 18]

TN   #13-0053    
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**New York  
14a**

[Agency *	Citation(s)	Groups Covered
<b>B. Optional Groups – Other Than Medically Needy (Continued)</b>		
42 CFR 435.223	[ ] 9.	Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:
1902(a)(10) (A)(ii) and 1905(a) of the Act	___	Individuals under the age of --
	___	21
	___	20
	___	19
	___	18
	___	Caretaker relatives
	___	Pregnant women]

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New York  
15

Agency *	Citation(s)	Groups Covered
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B. Optional Groups – Other Than Medically Needy  
(Continued)

42 CFR 435.230

**[X] (10) States using SSI criteria with agreements under sections 1616 and 1634 of the Act.**

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is --

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in the State.
- d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

  X   (1) All aged individuals.

  X   (2) All blind individuals.

  X   (3) All disabled individuals.

TN   #91-77  

Approval Date   March 11, 1992  

Supersedes TN   #86-29A  

Effective Date   October 01, 1991

New York  
16

Agency *	Citation(s)	Groups Covered
<p style="text-align: center;"><b>B. <u>Optional Groups – Other Than Medically Needy</u></b> <b>(Continued)</b></p>		
42 CFR 435.230	<p>— (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.</p> <p>— (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.</p> <p>— (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.</p> <p>— (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</p> <p>— (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230</p> <p>— (9) Individuals in additional classifications approved by the Secretary as follows:</p>	

TN #91-77  
Supersedes TN #86-29A

Approval Date March 11, 1992  
Effective Date October 01, 1991

New York  
16a

Agency *	Citation(s)	Groups Covered
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**B. Optional Groups – Other Than Medically Needy  
(Continued)**

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

  X   Yes.

       No.

The standards for optional State supplementary payments are listed in [Supplement 6 of ATTACHMENT 2.6-A](#).

TN   #91-77  

Approval Date   March 11, 1992  

Supersedes TN   NEW  

Effective Date   October 01, 1991

New York  
17

Agency *	Citation(s)	Groups Covered
<p style="text-align: center;"><b>B. <u>Optional Groups – Other Than Medically Needy</u></b> <b>(Continued)</b></p> <p>42 CFR 435.120 435.121 1902(a)(10) (A)(ii)(XI) of the Act</p>		
	[ ]	<p><b>11. <u>Section 1902 (f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.</u></b></p> <p>The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is --</p> <ul style="list-style-type: none"> <li>a. Based on need and paid in cash on a regular basis.</li> <li>b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.</li> <li>c. Available to all individuals in each classification and available on a Statewide basis.</li> <li>d. Paid to one or more of the classifications of individuals listed below: <ul style="list-style-type: none"> <li>___ (1) All aged individuals.</li> <li>___ (2) All blind individuals.</li> <li>___ (3) All disabled individuals.</li> </ul> </li> </ul>

TN #91-77  
Supersedes TN #87-35A

Approval Date March 11, 1992  
Effective Date October 01, 1991

**New York**  
**17a**

<b>[Agency *</b>	<b>Citation(s)</b>	<b>Groups Covered</b>
1902(a)(10) (A)(ii)(IX) and 1902(1) of the Act, P.L. 99-509 (Sections 9401(a) and (b))	___ 13.	<p>The following individuals who are not described in section 1902(a)(10)(A)(i) of the Act whose income level (established at an amount up to 100 percent of the Federal nonfarm poverty line) specified in <a href="#">Supplement 1 to ATTACHMENT 2.6-A</a> for a family of the same size, including the woman and infant or child and who meet the resource standards specified in <a href="#">Supplement 2 to ATTACHMENT 2.6-A</a>.</p> <p>(a) Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy) and infants under one year of age (effective April 1, 1987);</p> <p>___ (b) Children who have attained one year of age but not attained two years of age (effective October 1, 1987);</p> <p>___ (c) Children who have attained two years of age but not attained three years of age (effective October 1, 1988);</p> <p>___ (d) Children who have attained three years of age but not attained four years of age (effective October 1, 1989);</p> <p>___ (e) Children who have attained four years of age but not attained five years of age (effective October 1, 1990).]</p> <p>Infants and children covered under items 13(a) through (e) above who are receiving inpatient services on the date they reach the maximum age for coverage under the approved plan will continue to be eligible for inpatient services until the end of the stay for which the inpatient services are furnished.</p>

\* Agency that determines eligibility for coverage.

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**Effective Date** **January 1, 2014**

New York  
17b

Agency *	Citation(s)	Groups Covered
		<p>[The payment levels under the approved State AFDC plan are no lower than the AFDC payment levels in effect under the approved AFDC plan on April 17, 1986.</p> <p>[ ] Yes</p> <p>[X] Not applicable. The State does not provide coverage of this optional categorically needy group.]</p>
1902(a) (10)(A) (ii)(X) and 1902(m) (1) and (3) of the Act, P.L. 99-509 (Section 9402(a) and (b))	___ 14.	<p>In addition to individuals covered under item B.13, individuals --</p> <p>(a) Who are 65 years of age or older or are disabled --</p> <p>___ As determined under section 1614(a)(3) of the Act; or</p> <p>___ As determined under more restrictive categorical eligibility criteria specified under item A.9(b) of this Attachment.</p> <p>(b) Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal nonfarm income poverty line) specified in <a href="#">Supplement 1 to ATTACHMENT 2.6-A</a> for a family of the same size; and</p> <p>(c) Whose resources do not exceed the maximum amount allowed --</p> <p>___ Under SSI;</p> <p>___ Under the State's more restrictive financial criteria; or</p> <p>___ Under the State's medically needy program as specified in <a href="#">ATTACHMENT 2.6-A</a>.</p>

\* Agency that determines eligibility for coverage.

TN #13-0053

Approval Date June 26, 2014

Supersedes TN #87-0035A

Effective Date January 1, 2014

**New York  
17b-1**

[Agency *]	Citation(s)	Groups Covered
Section 4101(a) PL100-203 Sec 1902L (1)(A)(B) of the Act XIX	<input checked="" type="checkbox"/> 14Z	<p>The following individuals who are described in Section 1902L(1)(A)(B) of the Act whose income level (established at an amount up to 185% of the Federal nonfarm poverty line) specified in Supplement 1 page 2a to <a href="#">Attachment 2.6A</a> for a family of the same size including the woman or infant under one who meet the resource standards specified in <a href="#">Supplement 2 to Attachment 2.6A</a>.</p> <p>(a) Woman during pregnancy (and during the 60 day period beginning on the last day of pregnancy) and infants under one year of age (effective July1, 1988).</p> <p>(b) The resource standard &amp; methodology applied to the pregnant woman.</p> <p><input checked="" type="checkbox"/> The State does not apply a resource standard.</p> <p><input type="checkbox"/> The State applies a resource standard not more restrictive than SSI.</p> <p>(c) The resources standard &amp; methodology applied to the child under one year.</p> <p><input checked="" type="checkbox"/> The State does not apply a resource standard.</p> <p><input type="checkbox"/> The State applies a resource standard not more restrictive than AFDC.</p> <p>(d) Where the gross income of the pregnant woman or child (less child care expenses) exceeds 150% of the FPL for a family of relevant size a premium not to exceed 10% of the excess may be applied.</p> <p><input checked="" type="checkbox"/> The State does not apply a premium.</p> <p><input type="checkbox"/> The State applies a <input type="text"/> percent premium.]</p>
TN <u>#13-0053</u>		Approval Date <u>June 26, 2014</u>
Supersedes TN <u>#90-0003</u>		Effective Date <u>January 01, 2014</u>



New York  
17c

Agency *	Citation(s)	Groups Covered
[1902(a)(47) and 1920 of the Act, P.L. 99-509 (Section 9407)]	[ <u>X</u> ] 15.	Pregnant women who meet the applicable income levels for the categorically needy specified in this plan under <a href="#">Attachment 2.6A</a> who are determined eligible by a qualified provider during a presumptive eligibility period in accordance with section 1920 of the Act.]

**C. Optional Coverage of the Medically Needy**

Title XIX 435.301

This plan includes the medically needy.

     No

X Yes. This plan covers:

1. Pregnant women who, except for income and resources, would be eligible as categorically needy.

\* Agency that determines eligibility for coverage.

TN #13-0053

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New York  
18

Agency *	Citation(s)	Groups Covered
<p style="text-align: center;"><b>B. <u>Optional Groups Other Than the Medically Needy</u></b> <b>(Continued)</b></p>		
_____	(4)	Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
_____	(5)	Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
_____	(6)	Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
_____	(7)	Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
_____	(8)	Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
_____	(9)	Individuals in additional classifications approved by the Secretary as follows:

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New York  
18a

Agency *	Citation(s)	Groups Covered
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**B. Optional Groups Other Than the Medically Needy  
(Continued)**

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

\_\_\_ Yes

\_\_\_ No

The standards for optional State supplementary payments are listed in [Supplement 6 of ATTACHMENT 2.6-A](#)

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New York  
19

Agency *	Citation(s)	Groups Covered
<p style="text-align: center;"><b>B. <u>Optional Groups Other Than the Medically Needy</u></b> <b>(Continued)</b></p>		
42 CFR 435.231 1902(a)(10) (A)(ii)(V) of the Act	<input type="checkbox"/>	12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in <a href="#">Supplement 1 to ATTACHMENT 2.6-A</a> .
	<input type="checkbox"/>	The State covers all individuals as described above.
	<input type="checkbox"/>	The State covers only the following group or groups of individuals:
1902(a)(10)(A) (ii) and 1905(a) of the Act	<input type="checkbox"/>	Aged
	<input type="checkbox"/>	Blind
	<input type="checkbox"/>	Disabled
	<input type="checkbox"/>	Individuals under the age of --
	<input type="checkbox"/>	21
	<input type="checkbox"/>	20
	<input type="checkbox"/>	19
	<input type="checkbox"/>	18
	<input type="checkbox"/>	Caretaker relatives
	<input type="checkbox"/>	Pregnant women

 TN #91-77

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New York  
20

Agency *	Citation(s)	Groups Covered
<b>B. Optional Groups Other Than the Medically Needy (Continued)</b>		
1902(e)(3) of the Act	[ ]	13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in an institution, and for whom the State has made a determination as required under section 1902(a)(3)(B) of the Act.  <a href="#">Supplement 3 to ATTACHMENT 2.2-A</a> describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
[1902(a)(10)(A)(ii)(IX) and 1902(1) of the Act]	[[X]	14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in <a href="#">Supplement 1 to ATTACHMENT 2.6-A</a> for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in <a href="#">Supplement 2 to ATTACHMENT 2.6-A</a> :  a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and  b. Infants under one year of age.]

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New York  
21

[Agency *	Citation(s)	Groups Covered
<p style="text-align: center;"><b>B. Optional Groups Other Than the Medically Needy (Continued)</b></p>		
1902(a) (10)(A) (ii)(IX) and 1902(1)(1) (D) of the Act	[X]	<p>15. The following individuals who are not mandatory categorically needy, who have income that does not exceed the income level (established at an amount up to 100 percent of the Federal poverty level) specified in <a href="#">Supplement 1 of ATTACHMENT 2.6-A</a> for a family of the same size.</p> <p>Children who are born after September 30, 1983 and who have attained 6 years of age but have not attained --</p> <p>[ ] 7 years of age; or</p> <p>[X] 8 years of age.]</p>

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Agency *	Citation(s)	Groups Covered
B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)		
1902(a) (ii)(X) and 1902(m) (1) and (3) of the Act	<b>[X] 16. Individuals --</b>	<p>a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.</p> <p>b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in <a href="#">Supplement 1 to ATTACHMENT 2.6-A</a> for a family of the same size; and</p> <p>c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in <a href="#">ATTACHMENT 2.6-A</a>.</p>

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[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
COVERAGE AND CONDITIONS OF ELIGIBILITY]

Citation(s)	Groups Covered
<p style="text-align: center;"><b>B. Optional Groups Other Than the Medically Needy (Continued)</b></p>	
1902(a)(47) and 1920 of the Act	<div style="display: flex; align-items: flex-start;"> <div style="margin-right: 10px; text-align: center;"> <u>X</u> </div> <div>           17. Pregnant women who are determined by a "qualified provider" (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under <a href="#">ATTACHMENT 2.6-A</a> and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.]         </div> </div>

TN #13-0053  
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New York  
23a

Citation(s)	Groups Covered
<p style="text-align: center;"><b>B. <u>Optional Groups Other Than the Medically Needy</u></b> <b>(Continued)</b></p>	
1906 of the Act	18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of ____ months.
1902(a)(10)(F) and 1902(u)(1) of the Act	19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See <a href="#">Supplement 11 to Attachment 2.6-A</a> .

TN #91-77Approval Date March 11, 1992Supersedes TN NEWEffective Date October 01, 1991

**New York  
23b**

[Citation(s)]	Groups Covered
	<b>B. Optional Groups Other Than the Medically Needy (Continued)</b>
OBRA 1993 Sec. 1902(a)(10)(A)(ii – XII)	<p>Coverage is extended to individuals who are described in subsection (z)(1) relating to certain TB infected individuals whose income and resources are as follows:</p> <p><u>  X  </u> Income (as determined under the State plan under this title with respect to disabled individuals) does not exceed the maximum amount of income of a disabled individual described in subsection (a)(10)(A)(i).</p> <p><u>      </u> More liberal income disregards in accordance with section 1902(r)(2) as described in <a href="#">Supplement 8a to Attachment 2.6A</a> page 4 are applied.</p> <p><u>      </u> Resources (as determined under the State plan under this title with respect to disabled individuals) do not exceed the maximum amount of resources a disabled individual described in section (a)(10)(A)(i) may have.</p> <p><u>      </u> More liberal resource disregards in accordance with section 1902(r)(2) as described in <a href="#">Supplement 8b to Attachment 2.6A</a> page 4 are applied.]</p>

TN   #13-0053  Approval Date   June 26, 2014  Supersedes TN   #94-0014  Effective Date   January 1, 2014

**New York  
23c**

[Citation(s)]	Groups Covered
1902(a)(10)(A) (ii)(xiv) of the act	<p style="text-align: center;"><b>B. Optional Groups Other Than Medically Needy (Continued)</b></p>
	<p><u>  X  </u> <b>20. Optional Targeted Low Income Children who:</b></p> <ul style="list-style-type: none"> <li>a. are not eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spenddown liability);</li> <li>b. would not be eligible for Medicaid under the policies in the State's Medicaid plan as in effect on April 15, 1997 (other than because of the age expansion provided for in §1902(1)(2)(D));</li> <li>c. are not covered under a group health plan or other group health insurance (as such terms are defined in §2791 of the Public Health Service Act coverage) other than under a health insurance program in operation before July 1, 1997 offered by a State which receives no federal funds for the program;</li> <li>d. have family income at or below: <ul style="list-style-type: none"> <li>200 percent of the federal poverty level for the size family involved, as revised annually in the federal Register; or</li> <li>A percentage of the federal poverty level, which is in excess of the "Medicaid applicable income level" (as defined in §2110(b)(4) of the Act) but no more than 50 percentage points.</li> </ul> </li> </ul> <p><b>The State covers:</b></p> <p><u>  X  </u> All children described above who are under age 19 (18, 19) with family income at or below 100 percent of the federal poverty level.]</p>

TN   #13-0053  Approval Date   June 26, 2014  Supersedes TN   #99-0002  Effective Date   January 1, 2014

**New York  
23d**

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**Citation(s)**


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**Groups Covered**


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**[B. Optional Groups Other Than Medically Needy  
(Continued)**

\_\_\_\_ The following reasonable classifications of children described above who are under age \_\_\_\_ (18,19) with family income at or below the percent of the federal poverty level specified for the classifications:

(Add Narrative Descriptions(s) Of The Reasonable Classification(s) And The Percent Of The Federal Poverty Level Used To Establish Eligibility For Each Classification.)]

1920A(b)(3)(A)  
of the Act

**X** **21. Continuous Eligibility For Children**

A child under age 19 (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of 12 months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.

[1902A(b)(3)(A)  
of the Act]

**X** **22. Presumptive Eligibility For Children**

Children under age 19 who are determined by a "qualified entity" (as determined in §1920(A)(b)(3)(A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan.

The presumptive period begins on the day that the determination is made. If an application for Medicaid is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the State agency makes a determination of eligibility based on that application. If the application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on the last day.]

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Citation(s)	Groups Covered
<p style="text-align: center;"><b>B. <u>Optional Groups Other Than Medically Needy</u> (Continued)</b></p>	
1902(a)(10)(A) (ii)(XVIII) of the Act	<p><u>X</u> 23. <b>Women who:</b></p> <ul style="list-style-type: none"> <li>a. have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;</li> <li>b. are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act;</li> <li>c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and</li> <li>d. have not attained age 65.</li> </ul>
1920B of the Act	<p><u>X</u> 24. Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) the Act related to certain breast and cervical cancer patients.</p> <p>The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive periods ends on that last day.</p>

TN #02-18  
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Citation	Groups Covered
	<p><b>B. <u>Optional Groups Other Than the Medically Needy</u></b> <b>(Continued)</b></p>
<p>1902(a)(10)(A) (ii)(XIII) of the Act</p>	<p><u>    </u> <b>25. BBA Work Incentives Eligibility Group –</b></p> <p>Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12 c of <a href="#">Attachment 2.6-A</a>.</p>
<p>1902(a)(10)(A) (ii)(XV) of the Act</p>	<p><u>  X  </u> <b>26. TWWIIA Basic Coverage Group –</b> Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of <a href="#">Attachment 2.6-A</a>.</p>
<p>1902(a)(10)(A) (ii)(XVI) of the Act</p>	<p><u>  X  </u> <b>27. TWWIIA Medical Improvement Group –</b></p> <p>Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of <a href="#">Attachment 2.6-A</a>.</p> <p>NOTE: If the State elects to cover this group, it MUST also cover the basic coverage Group Described in No. 26 above.</p>

TN   #03-11    
Supersedes TN   NEW  

Approval Date   June 26, 2003    
Effective Date   July 01, 2003

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23g

[Citation]

Groups Covered

**B. Optional Groups Other Than the Medically Needy  
(Continued)**

Sections 477,  
1902(a)(10)(A)(ii)(XVII),  
and 1905(w) of the Act

  X  **28. Independent Foster Care Adolescents.**

An individual who is younger than age 21, who on the individual's 18<sup>th</sup> birthday was in foster care under the responsibility of a State, who meets the targeting criteria in a.) below, and whose income and resources do not exceed the level(s), if any, established in b.) below.

## a. Individuals who meet the following criteria:

- 1) Are under the age of:   X   21  
    20  
    19

- 2) Are:   X   All such individuals.  
                  Individuals for whom foster care maintenance payments or independent living services were furnished under a program funded under title IV-E before the date the individuals turned 18 years old.  
                  Other reasonable classifications:

## b. Financial requirements

- 1) Income test:   X   There is no income test.  
    The income test is:
- 2) Resource test:   X   There is no resource test.  
    The resource test is:

Note: If there is an income or resource test, the standards and methodologies may not be more restrictive than those for the State's section 1931 population, as specified in Supplement 12 of Attachment 2.6-A.]

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**[B. Optional Groups Other Than the Medically Needy (Continued)]**

**Citation: 1902(a)(10)(A)(ii)(XXI) and 1902(ii)**

[X] Individuals who are *not* pregnant and whose income does not exceed the State established income standard of 200% of the Federal Poverty Level. This amount does not exceed the highest income limit for pregnant women in this State Plan, which is 200% of the Federal Poverty Level.

[ ] In determining eligibility for this group, the State considers only the income of the applicant or recipient.

[X] In determining eligibility for this group, the State will apply the income disregards listed in Supplement 8A to Attachment 2.6-A of the State Plan.

Note: Services are limited to family planning services and family planning-related services as described in section 4.c.ii of Attachment 3.1-A of the State Plan.

**Citation: 1920C - Presumptive Eligibility for Family Planning:**

[X] The State provides a period of presumptive eligibility for family planning services to individuals determined by a qualified entity, based on preliminary information from the individual, described in the group the State has elected to make eligible under the above option.

The period of presumptive eligibility ends on the earlier of the date a formal determination of Medicaid eligibility is made under 1902(a)(10)(A)(ii)(XXI), or, when no application has been filed, the last day of the month following the month during which the qualified entity determines the individual presumptively eligible.

[X] In addition to family planning services, the State covers family planning-related services to such individuals during the period of presumptive eligibility.]

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Agency *	Citation(s)	Groups Covered
	<b>C. <u>Optional Coverage of the Medically Needy</u></b>	
42 CFR 35.301	This plan includes the medically needy.	
	[ ] No.	
	[X] Yes. This plan covers:	
	1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.	
1902(e) of the Act	2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.	
1902(a)(10)(C)(ii)(I) of the Act	3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.	

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Agency *	Citation(s)	Groups Covered
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**C. Optional Coverage of Medically Needy (Continued)**

[1902(e)(4) of the Act]	4.	Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible and the child is a member of the woman's household.]
42 CFR 435.308	5.	<div style="margin-left: 20px;"> <input checked="" type="checkbox"/> a. Financially eligible individuals who are not described in section C.3. above and who are under the age of -- <div style="margin-left: 40px;"> <div style="display: flex; align-items: center;"> <div style="width: 40px; border-bottom: 1px solid black; margin-bottom: 2px;"></div> <div style="margin-bottom: 2px;">21</div> </div> <div style="display: flex; align-items: center;"> <div style="width: 40px; border-bottom: 1px solid black; margin-bottom: 2px;"></div> <div style="margin-bottom: 2px;">20</div> </div> <div style="display: flex; align-items: center;"> <div style="width: 40px; border-bottom: 1px solid black; margin-bottom: 2px;"></div> <div style="margin-bottom: 2px;">19</div> </div> <div style="display: flex; align-items: center;"> <div style="width: 40px; border-bottom: 1px solid black; margin-bottom: 2px;"></div> <div>18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training</div> </div> </div> <div style="margin-left: 20px; margin-top: 10px;"> <input type="checkbox"/> b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below: <div style="margin-left: 40px; margin-top: 10px;"> <div style="display: flex; align-items: center;"> <div style="width: 40px; border-bottom: 1px solid black; margin-bottom: 2px;"></div> <div>(1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:</div> </div> <div style="margin-left: 40px; margin-top: 10px;"> <div style="display: flex; align-items: center;"> <div style="width: 40px; border-bottom: 1px solid black; margin-bottom: 2px;"></div> <div>(a) In foster homes (and are under the age of ____).</div> </div> <div style="display: flex; align-items: center;"> <div style="width: 40px; border-bottom: 1px solid black; margin-bottom: 2px;"></div> <div>(b) In private institutions (and are under the age of ____).</div> </div> </div> </div> </div> </div>

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Agency *	Citation(s)	Groups Covered
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**C. Optional Coverage of Medically Needy (Continued)**

- \_\_\_

\_\_\_

\_\_\_

\_\_\_

\_\_\_

\_\_\_

(c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of \_\_\_).

(2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of \_\_\_).

(3) Individuals in NFs (who are under the age of \_\_\_). NF services are provided under this plan.

(4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of \_\_\_).

(5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of \_\_\_). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

(6) Other defined groups (and ages), as specified in Supplement 1 of [ATTACHMENT 2.2-A](#).

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Agency *	Citation(s)	Groups Covered
<b>C. <u>Optional Coverage of Medically Needy</u> (Continued)</b>		
42 CFR 435.310	[X]	6. Caretaker relatives.
42 CFR 435.320 and 435.330	[X]	7. Aged individuals.
42 CFR 435.322 and 435.330	[X]	8. Blind Individuals.
42 CFR 435.324 and 435.330	[X]	9. Disabled individuals.
42 CFR 435.326	[X]	10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.
435.340		11. Blind and disabled individuals who: <ul style="list-style-type: none"> <li>a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;</li> <li>b. Were eligible as medically needy in December 1973 as blind or disabled; and</li> <li>c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.</li> </ul>

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Agency *	Citation(s)	Groups Covered
<p style="text-align: center;"><b>C. <u>Optional Coverage of Medically Needy</u> (Continued)</b></p>		
1906 of the Act	12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of ____ months.	

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**Populations Which Will Be Excluded Or Exempt From Managed Care  
They Have Serious And/Or Complex Medical And/Or Emotional Needs**

**I. Excluded Populations**

In addition to the Medicaid eligibles previously identified, the following Medicaid population groups will not be eligible for enrollment under this SPA.

1. Children in State-operated psychiatric facilities and residential treatment facilities for children and youth.
2. Children who are residents of residential health care facilities at the time of enrollment and children who enter a residential health care facility subsequent to enrollment, except for short-term rehabilitative stays anticipated to be no greater than 30 days.
3. Medicaid eligible infants living with an incarcerated mother.
4. Infants weighing less than 1200 grams at birth and other infants under six months of age who meet the criteria for the SSI related category (shall not be enrolled or shall be disenrolled retroactive to date of birth).
5. Children with access to comprehensive private health care coverage that is available from or under a third-party payor which may be maintained by payment, or part payment, of the premium or cost-sharing amounts, when payment of such premium or cost-sharing amounts would be cost-effective, as determined by the local social services district.
6. Children expected to be eligible for Medicaid for less than six months.
7. Homeless children residing in a NYC DHS and not enrolled in a plan at the time they enter the shelter.
8. Children in receipt (at the time of enrollment) of institutional long-term care (except ICF services for the Developmentally Disabled), Long Term Home Health Care programs, Child Care Facilities, or Hospice.
9. Children receiving mental health family care services.
10. Children enrolled in the Restricted Recipient Program.

**II. Voluntary (Exempt) Populations**

There are a number of population groups that will be eligible for an exemption from mandatory enrollment. (Information on the exemption criteria and process will be

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included in the enrollment materials sent to all potential eligibles. A separate pamphlet will discuss the implications and conditions of any exemptions from enrollment which are allowed). Children who fall into one of the following categories will be enrolled only on a voluntary basis:

1. *Children who are HIV+.* Once SNPs are established and certified through the milestone process, children with HIV disease must enroll in a managed care arrangement (either mainstream MCOs or SNPs). As soon as HIV SNPs are established through the milestone process in a given service area, those HIV positive children in that area who have voluntarily enrolled in mainstream MCOs will be given the option of enrolling in a SNP.
2. *Children who are diagnosed seriously emotionally disturbed (SED).* Children who have utilized 10 or more mental health visits (mental health clinic services or mental health specialty services, or a combination of these services) in the previous calendar year will be SED. Once SNPs are established and certified through the milestone process, enrollment in SNPs will remain voluntary for the SNP-eligible population, with the exception of SED children who have not selected a mental health option and are auto-assigned to a mental health SNP. These children will be mandatorily enrolled in a certified SNP for receipt of mental health services. However, a FFS option for mental health services will only be offered in counties where there is only one mental health SNP which is operated by the county.

If SNPs are not eventually established in certain areas of the State, children who would otherwise be eligible for enrollment in mental health SNPs may: (a) receive both mental health and physical benefits on a FFS basis; (b) voluntarily enroll in certified mainstream MCOs and receive the same physical and mental health services available to other Partnership Plan enrollees residing in the same service area; or (c) voluntarily enroll in certified mainstream MCOs for the provision of physical health-only services and receive mental health benefits on a FFS basis.

3. *Children for whom a managed care provider is not geographically accessible* so as to reasonably provide services. To qualify for this exemption, a person must demonstrate that no participating MCO has a provider located within thirty minutes travel time from the children's home who is accepting new patients, and that there is a fee-for-service Medicaid provider available within the thirty minutes travel time.
4. *Pregnant women who are already receiving prenatal care from a prenatal primary care provider* not participating in any managed care plan (note: this status will last through a woman's pregnancy and sixty (60) days postpartum; after that time, she will be enrolled mandatorily into an MCO if she belongs to one of the mandatory aid categories).
5. *Children with a chronic medical condition* who, for at least six months, have been under active treatment with a non-participating subspecialist physician who is not a network provider for any MCO participating in the Medicaid managed care program service area.

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6. *Children with end state renal disease (ESRD).*
7. *Children who are residents of Intermediate Care Facilities for the Mentally Retarded (ICF/MR).*
8. *Children with characteristics and needs similar to those who are residents of ICF/MRs based on criteria cooperatively established by the State Office of Mental Retardation and Developmental Disabilities (OMRDD) and the NYS Department of Health (DOH).*
9. *Children already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of an MCO under contract for The Partnership Plan.*
10. *Children with a developmental or physical disability who receive services through a Medicaid Home-and-Community-Based Services waiver or Medicaid Model Waiver (care-at-home) through a Section 1915c waiver, or children having characteristics and needs similar to such children (including children on the waiting list), based on criteria cooperatively established by OMRDD and DOH.*
11. *Children who are residents of Alcohol and Substance Abuse Long Term Residential Treatment Programs.*
12. *New York City beneficiaries who are homeless and do not reside in a DHS shelter are exempt. Homeless children residing in a NYC DHS shelter and already enrolled in a plan at the time they enter the shelter may choose to remain enrolled. In areas outside of NYC, exemption of homeless children residing in the shelter system is at the discretion of the local district.*
13. *Children who cannot be served by a managed care provider due to a language barrier which exists when the child is not capable of effectively communicating his or her medical needs in English or a secondary language for which PCPs are available in the managed care program. Children with a language barrier still have a choice of three (3) PCPs, at least one of which is able to communicate in the primary language of the child or has a person on her/his staff capable of translating medical terminology, and the other two (2) PCPs have access to the AT&T Language Line as an alternative to communicating directly with the child in his/her language. Children will be eligible for an exemption when:*
  - The child has established a relationship with a primary care provider who has the language capability to serve the child and who does not participate in any of the managed care plans available within a thirty minute/thirty mile radius of the child's residence.
  - Neither fee-for-service nor the above described three (3) participating PCPs are available within the thirty minute/thirty mile radius, and a fee-for-service provider with the language capability to serve the child is available outside the thirty minute/thirty mile radius and the above-described three (3) participating PCPs are not available within that radius.

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14. *Children with a County of Fiscal/Responsibility code of 98 (OMRDD in MMIS) will be exempt until the state establishes appropriate program features.* Recipients with a code of 97 (OMH in MMIS) will be mandatorily enrolled when the state establishes appropriate program features. However, many of these children will qualify for other exemptions (SED) or exclusions.
15. *Children temporarily residing out of district, (e.g., college students) will be exempt until such time as the purpose of the absence is accomplished.* The definition of temporary absence is set forth in Social Services regulations at Title 18 Section 360-1.4(p). These children will have difficulty accessing services within travel time and distance standards.

Note: Any exemption granted to children with chronic medical conditions being treated by a non-participating sub-specialist physician or those scheduled for major surgical procedures prior to enrollment with a provider outside the MCO network will apply only until such time as the child's course of treatment is completed. Such exemptions must be renewed annually. The treating physician will determine when a child's course of treatment is completed. However, if the child's treating physician subsequently becomes a network provider for one the of the participating MCOs the exemption will no longer apply.

Determination of a child's eligibility for exemption will be conducted by local districts upon the request of the individual or his/her designee. Local districts (or the broker) will follow state guidelines in determining eligibility for exemption. When exemption status is unclear, the district may request assistance from the SDOH Office of Managed Care.

Children may request an exemption to enrollment in an MCO. Children eligible for an exemption who choose to enroll in managed care will be treated as voluntary enrollees for purposes of disenrollment provisions. Accordingly, these children may disenroll from an MCO with thirty days notice and return to the fee-for-service program.

Children who become eligible for exemption due to a change in eligibility status after they have enrolled in managed care may apply for an exemption and be disenrolled within 30-60 days. All managed care enrollees will have received information on the exemption criteria and process in the enrollment kits.

### **III. Other Children with Unusually Severe Chronic Care or Complex Referral Needs**

The SDOH Medical Director for Managed Care will, upon the request of an enrollee or his/her guardian, review for a possible exemption from mandatory enrollment in managed care cases of children with unusually severe chronic care needs if such children are not otherwise eligible for an exemption (i.e., meet one of the criteria listed in the previous section). The Medical Director may also authorize disenrollment for such children.

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**IDENTIFICATION OF CHILDREN TO BE EXCLUDED OR EXEMPT WHO HAVE  
SERIOUS AND/OR COMPLEX MEDICAL AND EMOTIONAL NEEDS**

The local social services districts (LDSS) in New York State will assume primary responsibility for the enrollment process under this State Plan Amendment. Under the existing Medicaid program, each LDSS is responsible for the determination of Medicaid eligibility. LDSS operations, including policies and staffing, will be enhanced to accommodate the new program established under this SPA. LDSS responsibilities (with assistance from SDOH) will include identification of excluded and exempt populations, including the handling of exemption requests.

Children may be either excluded or exempted from mandatory participation. Excluded populations will not participate; exempt populations are not required to participate. However, children designated as exempt may elect to voluntarily enroll.

In some cases, the State and LDSS can identify exempt populations through existing claims and eligibility data. Some excluded populations can be identified through the eligibility system. The State and/or LDSS will append the eligibility records with an identifier that will enable the Enrollment and Benefits Counselor or the Local District to determine whether a child is exempt from mandatory participation. In cases where the State can determine in advance a child's exempt status the system will flag this child's eligibility files to prevent an auto-assignment from taking place. However, in the case of children who may be exempt, but cannot be identified in advance and certain children actually eligible for an exemption in other categories), the algorithm will assign these children to an MCO unless they actually apply for and receive an exemption from the LDSS.

Children who are identified as exempt through analysis of existing aid category or through claims data will not receive a notice indicating that the State has found them to be exempt from mandatory participation. Exempt children will be informed of their option to enroll in an MCO or be waived from mandatory participation. These children will be receiving the same enrollment package as others being recertified or applying for assistance. This package includes information on exemptions and who is eligible. However, the recipients case will be electronically flagged as exempt which will prevent auto-assignment. Exempt children so flagged will not receive a reminder notice regarding the requirement to enroll in a MCO. If the recipient chooses to enroll in an MCO, the worker inputting the enrollment information will get a computer message that alerts him/her that an exemption code is on file, and if the client chooses to disenroll at a later date, will not be auto-assigned as long as that exemption code remains.

In certain cases, the State and LDSS may lack the information necessary to determine in advance whether the child is exempt from participation. Accordingly, the State has developed an exemption application to enable such children to apply for exemption from participation. The LDSS will collect and process applications for exemption from mandatory participation. The exemption application forms and criteria for approving or

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denying requests shall be provided by the State to the LDSS. Exemption forms, including the look-alike screening form, are available to beneficiaries through the LDSS.

Eligible enrollees may apply for an exemption at any time. However, if the child is enrolled already in an MCO, s/he may be required to access services through the MCO until the LDSS and State have had the opportunity to process the application and disenroll the child from an MCO.

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**SPA County Participation**

Counties with 2 MCOs*	Counties with 1 MCO in Rural Areas*	Counties with no MCOs or 1 MCO in Urban Areas
Albany	Cortland	Allegany
Broome	Delaware	Cayuga
Cattaraugus	Fulton	Chemung
Chautauqua	Genesee	Chenango
Columbia	Herkimer	Clinton
Erie	Montgomery	Dutchess
Greene	Otsego	Essex
Livingston	Putnam	Franklin
Monroe	Schenectady	Hamilton
Nassau	Schoharie	Jefferson
Niagara	Seneca	Lewis
Oneida	Sullivan	Madison
Ontario	Tioga	St. Lawrence
Onondaga	Ulster	Schuyler
Orange	Warren	Steuben
Orleans	Yates	Tompkins
Oswego		Wyoming
Rensselaer		
Rockland		
Saratoga		
Suffolk		
Westchester		
Washington		
Wayne		
New York City		

\* These counties will be participating as mandatory Medicaid managed care counties under this SPA.

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**Rural Area Residents**

For recipients who reside in a rural area with a single MCO, the State will limit enrollment to such MCO, provided however, such recipient may:

- 1 Choose from at least two physicians or case managers; and
2. Obtain services from any other provider under the following circumstances:
  - (a) The service or type of provider is not available within the MCO network.
  - (b) The provider is not part of the MCO network, but has an existing relationship with the recipient.
  - (c) The only plan or provider available to the recipient does not, because of moral or religious objections, provide the service the enrollee seeks.
  - (d) The State determines that other circumstances warrant out-of-network treatment.

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**Methodology and Process For Capacity/Network Analysis**

A managed care organization (MCO) provider network consists of physicians, groups(s) of physicians, specialists and the service centers, i.e., hospitals, pharmacy, clinics, etc. that are contracted to the MCO to provide all of the health care services that may be required by enrollees. The MCO, through its provider network, must plan, direct, coordinate, and provide for the health care services of every enrollee.

The New York State Department of Health (SDOH), in conjunction with the Local Departments of Social Services (LDSS) and the New York City Office of Medicaid Managed Care (OMMC) will evaluate the provider networks of every MCO to determine that it has an adequate network that will be accessible to all enrollees for their health care needs. This review ensures that the MCO has the adequate capacity in its provider network to meet the needs of the target population and there is an adequate network structure.

To serve the Medicaid population in New York State, an MCO must successfully complete the Certification of Authority (COA) process. Review and evaluation of the provider network are essential components of the Certification process since the inception of Article 44 of the Public Health Law.

MCO network evaluation is a multi-step process. To qualify, a MCO network has to achieve a successful quantitative score assigned by SDOH using a Statistical Analysis Software (SAS) program. Then the network has to pass the scrutiny of the LDSS, which evaluates the network for compliance with time and distance standards. The third and final step is verification of the network during the Readiness Review conducted by SDOH Area Office staff just prior to an MCO becoming operational. During the Readiness Review site visits contracts are pulled to verify the network information submitted by the MCO.

The following discussion provides the necessary information to understand how SDOH calculates and monitors Medicaid MCO capacity on an on-going basis.

**A. Network Adequacy Definition**

Pursuant to Section 98.5(b)(9) of Title 10, NYCRR, each fully capitated MCO is required to provide:

"Identification of the type of HMO that is proposed and a description of the service delivery system of the proposed HMO, including the numbers and locations of primary care providers and providers of other services such as ambulatory, ancillary and hospital services;..."

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In addition, pursuant to Section 98.16(a) of Title 10, NYCRR, MCOs must submit an annual listing of providers and facilities by location. Section 364-j(8)(f) &(g) of the Social Services Law requires:

“(f) Every managed care provider shall ensure that the provider maintains a network of health care providers adequate to meet the comprehensive health needs of its participants and to provide an appropriate choice of providers sufficient to provide the services to its participants by determining that:

- (i) there are a sufficient number of geographically accessible participating providers;
- (ii) there are opportunities to select from at least three primary care providers; and
- (iii) there are sufficient providers in each area of specialty practice to meet the needs of the enrolled population.

(g) The commissioner of health shall establish standards to ensure that managed care providers have sufficient capacity to meet the needs of their enrollees, which shall include patient to provider ratios, travel and distance standards and appropriate waiting times for appointments.”

### **1. Providers and Service Centers**

The MCO provider network must include providers for services included in a core benefit package (listed below) which is required for certification. If the MCO does not directly provide such services, contractual relationships with appropriately qualified providers must exist prior to certification. In addition to the core providers, the network must contain any other providers necessary to provide all the health care services included in the benefit package. If, for example, the MCO covers podiatry services, the network must contain a podiatrist in each service area. The following lists the core group of providers and services required for certification.

#### **Medicaid Core Benefit Package**

<u>Provider File:</u>	<u>Provider File:</u>	<u>Service/Ancillary File:</u>	<u>Service/Ancillary File or Provider File:</u>
<u>Primary Care</u>	<u>Specialty Care</u>	<u>Ancillary/Tertiary Care</u>	<u>Specialty Care</u>
Family Practice	Allergy/Immunology	Ambulance	Anesthesiology
General Practice	Cardiology	Durable Medical Equipment	Audiology
Internal Medicine	Dermatology	Home Health Care	Infectious Disease
Pediatrics	Gastroenterology	Hospitals	Radiology
OB/GYN as PCP	General Surgery	Medical Laboratories	Optometry

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Certified Nurse Midwife	Geriatrics	Pharmacies	Pathology
Nurse Practitioner	Nephrology	Alcohol and Chemical Dependency Inpatient and Outpatient	Social Work
	Neurology	Mental Health Inpatient and Outpatient	Therapy: Physical
	Obstetric/Gynecology		Therapy: Speech/Language
	Oncology/Hematology		Therapy: Occupational
	Optometry		
	Ophthalmology		
	Orthopedics		
	Otolaryngology (ENT)		
	Psychiatry		
	Psychology		
	Podiatry		
	Pulmonary Medicine		
	Urology		
	Dentistry**		

\*\*=Optional benefit, not a mandatory benefit

## 2. Network Adequacy Determination

The Bureau of Certification and Surveillance within SDOH is responsible for assessing the adequacy of the network. While obstetricians, gynecologists and certified nurse mid-wives are not generally considered primary care providers, these specialties may be included with the Primary Care Physician (PCP) grouping because they may act as a PCP if they have met SDOH qualifications. Part of the adequacy determination is evaluating whether the MCO has a sufficient number of PCPs to allow the member to have choice.

## B. Network Capacity Definition

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Most often, the capacity of a provider may depend on the efficiency of the doctor and her associated staff. Capacity may be defined as either a member-to-provider ratio or a maximum number of enrollees a primary care provider can properly handle on a full time basis (i.e., 40 hrs/week). The SDOH is using a combination of these two definitions. SDOH is using the following definition of capacity.

“MCOs must adhere to the member-to-PCP ratios shown below. These ratios are for Medicaid members only, are MCO-specific, and assume that the practitioner is an FTE (practices 40 hours per week for the MCO):

- No more than 1,500 Medicaid members for each physician, or 2,400 for a physician practicing in combination with a physician assistant. (i.e., a physician extender adds 900 to physician capacity)
- No more than 1,000 Medicaid members for each nurse practitioner. (RFP, p.34)”

The above ratios are used as an initial starting point for the analysis of capacity.

Additionally, SDOH uses the following additional criteria for Article 28 comprehensive community-based primary care provider centers and Outpatient Departments of Hospitals (OPDs).

- Individual providers practicing in Article 28 Comprehensive Community based Primary Care centers may have 3,000 enrollees: 1 PCP and practicing with a Physician Extender they may have 4,000 enrollees: 1 PCP with a physician extender
- Individual providers with practices based primarily in OPDs may have 2,500 enrollees: 1 PCP and practicing with a Year 2 or 3 resident they may have 4,000 enrollees: 1 PCP and FTE Resident.

### **C. Capacity Calculation and Process**

It is important to recognize that there are technically two types of capacity reviewed by the SDOH for each MCO: potential capacity and financial capacity. Potential capacity refers to the number of enrollees that can be managed by the existing provider network. Financial capacity is defined as the capacity that is financial feasible for the MCO to pay for based on their available capital and escrow deposit reserve requirement.

The following discussion details how the potential capacity is calculated; thus, the term capacity in the following section refers to the potential or calculated network capacity. Throughout the process of examining capacity it is also important to note that the value placed on capacity of the number of enrollees that a PCP may serve greatly controls the outcome of the capacity algorithm.

#### **1. Potential Provider Capacity**

The first step in calculating capacity for a MCO is the collection of data. SDOH collects network data electronically on an intranet system referred to as the Health Provider

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Network (HPN). This system was established in winter, 1996 for SDOH to collect information electronically from the MCOs. The MCOs are connected to the SDOH by a modem on their personal computer; they submit the data electronically in a specified format, the data is then edited immediately and a report is sent back to the MCOs with the number of records accepted along with an explanation of the records with errors. The steps below outline the methodology created for the entire provider network calculation of capacity.

- Health Provider Network
  - a. Elimination of incomplete or incorrect data
  - b. Electronic edit program
- Capacity Program
  - a. Matching to Physician License Master File
  - b. PCP Calculated Capacity based on FTE
  - c. PCP Calculated Capacity within and across MCOs
  - d. Capacity for each county

**a. Health Provider Network (HPN) Process**

As described above, all of the MCOs are required to submit provider network information on the SDOHs intranet system called the Health Provider Network (HPN). The details for submitting the provider network information are outlined in the *Data Dictionary for Managed Care Provider Network*. There are two files that are sent electronically to the SDOH, a provider file on people or physicians and other providers that are contacted to provide services to the members and a service file on places that are contacted with the MCO. Only the provider file is the used for the capacity calculation.

**I. Elimination of Incomplete Data**

Each submitted provider network record must contain certain data elements which, if omitted, will result in the deletion of a provider record. The required data elements are listed below:

- Last Name
- First Name
- License Number
- County Code
- Address (Street, Town/City)
- Board Status
- Primary Specialty
- Provider Type
- Primary Designation
- Residency Status
- Physician Status
- Panel Status

Data Elements for Primary Care Providers (PCPs) Only- all office hours

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If any of these data elements are missing or incorrectly coded by the MCO, it will receive an error message for the record(s) containing the missing element.

## **II. Electronic Edit Program**

The edit program on the HPS currently checks for 46 different errors on the provider file; 20 of these are classified as critical or "hard" errors; the remaining errors are referred to as soft errors. MCOs are required to pass all critical errors for the data submission to be acceptable for use in any analysis. If they have not passed critical errors on the day after the submission is due (it is due 15 business days after the end of the calendar quarter) then the MCO is sent a letter requesting that their submission be corrected.

### **2. Capacity Program**

The capacity program was developed using the SAS programming language. The quarterly provider file from the HPN and the physician master file from the NYS Department of Education are the two data sets used in the program. A Primary Care Provider or PCP subset of the Provider File data file is created for New York State providers indicated to be a Medicaid Primary Care Provider.

(Primary Care Providers are identified by editing the primary designation (PRIMDESG) and primary specialty (PRIMSPEC) fields; i.e., PRIMDESG values must equal 1=PCP and/or 3=PCP and Specialist AND PRIMSPEC values must equal 050' (Family Practice), 060' (Internal Medicine), 182' or 776' (General Practice), 150' (General Pediatrics) OR 089', 159', 169', (OB/GYN providers) (OBG/GYN are subject to DOH qualifications). The STATE data field must equal NY.

#### **a.) Matching to the Physician License Master File**

The first step involves a match of the physician/provider license number on the HPN provider file to the NYS Education file. This is to verify that the physicians on the HPN are currently licensed and registered to practice. During this step a variable is created on each data file to define each individual provider; this variable is created by the concatenation of the last three digits in the provider's last name and their license number. The records that match on both the HPN provider file and the education file are then stored in a data set, called PCPCAP, to be used for the remainder of the capacity program.

#### **b.) PCP Capacity for Each Individual Provider**

The next steps involve the calculation of capacity for each individual PCP using the member-to-provider ratios previously described. Several new variables are created within the PCPCAP data set for use in the capacity program. There are:

TOTOFFHR (Total Office Hours). This represents the sum of all available office hours. The maximum office hours attributed to an individual provider is 40. If the provider's total office hours across MCOs and sites exceeds 40, the hours

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at each site and MCO are reduced and allocated to each site on a prorated basis.

UNIQSITE (each providers location for each MCO). This variable accounts for the unique MCO and location for each provider and is constructed by concatenating the MCO identifier, provider license number and location address (site name, street number, room number, and street name). Many IPA and network model MCOs have overlapping provider networks, thus many of the providers are not unique to a *particular* MCO. (Usually, providers belonging to a staff or group model MCOs are unique to one program). To determine the effect of this on the capacity for each MCO, this field was created to capture the unique capacity that each MCO is offering.

TOTMPANL (Total Medicaid Panel Size). This is the sum of the total Medicaid panel or the total of the capitated enrollees that are recorded for a particular provider in each MCO. This will sum the panel size for all Medicaid MCOs.

FTE (Full Time Equivalent). TOTOFFHR are used to create a Full time equivalent of FTE based upon 40 hours per week. This is done by examining the multiple sites that a provider may have within an MCO and the multiple number of MCOs that a provider may belong to, i.e., a provider may be contracted in more than one MCO.

Only PCPs with TOTOFFHR (total office hours) equaling 16 hours of more per location are selected; this criteria is modified for residents; second year resident physicians must practice at least (8) continuity of care hours per week at a primary site; third and fourth year residents must practice at least twelve (12) continuity of care hours per week at a primary site. If a provider's total office hours at a particular site is below program minimum standards, his/her record *is deleted*.

The remaining steps calculate the PCP capacity for each provider. Specifically, the remaining steps are:

- For non-medical resident physicians practicing alone, capacity will be set equal to the lesser of: actual capacity reported or  $1,500 * FTE$

Under this formula, a physician practicing full time would have a maximum capacity of  $1,500 * 40/40 = 1,500$ .

- For PGY2 medical residents physicians, as denoted by 2" in the Resident Status filed, capacity will be set equal to the lesser of: actual capacity reported or  $750 * FTE$
- For PGY3 medical residents physicians, as denoted by 3" in the Resident Status filed, capacity will be set equal to the lesser of: actual capacity reported or  $1,125 * FTE$
- For PGY4 medical residents physicians, as denoted by 4" in the Resident Status filed, capacity will be set equal to the

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lesser of: actual capacity reported or  $1,500 * FTE$

- For nurse practitioners and certified midwives, capacity will be set equal to the lesser of: actual capacity reported or  $1,500 * FTE$
- The sum of the Medicaid panel size for every MCO that a provider identified is then subtracted from the potential capacity for only those physicians having an open panel.
- Physicians that have a closed panel for any MCO are assigned the Medicaid panel size for their capacity.

**c.) Capacity Calculation Within And Across MCOs**

After the above calculations are made, the program can identify providers if they practiced in multiple MCOs. For those providers, the total reported office hours across sites are summed and compared against a maximum of 40 hours. If the total exceeded 40 hours, the hours at each site and MCO were prorated down and the capacity at each MCO also is prorated accordingly. For example, if a provider reported working 40 hours at MCO A and 40 hours at MCO B (80 hours in total), and reported a capacity of 1,500 at each site, the provider's capacity was reset to equal 750 at each site. She would be counted as a .5 FTE for each MCO.

The next step in the capacity program summarizes the adjusted provider-specific capacity for each MCO. The summation of all the capacity values for each of the individual PCPs determines the MCO's total capacity.

**d.) Capacity for Each County**

The final step in the capacity program produces the capacity for all MCO and county combinations; the county service area is based on the geographic border of the location of the physicians within the county borders

**C. Financial Capacity**

In addition to the worksheets on provider network information, MCOs are also asked to provide Revenue and Expense and enrollment projections. These are statements detailing the capacity that could be supported by their financial reserves and capital.

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**D. Borough/County Network Analysis**

New York City and the individual counties also will evaluate provider networks. The City and counties are sent a Network Composition proposal for each of the MCOs proposing for contract. They then were responsible for assembling local review teams to examine the proposals and complete a County Network Evaluation Form. (Training has been provided to City and county evaluators to ensure that proposals were reviewed in a consistent manner across the State.)

The Borough/County Network form was designed to supplement the information captured through the State Network Evaluation, by asking New York City and the other LDSS to:

- verify that the distribution of providers re: travel time/distance standards for PCPs, hospitals, and pharmacies;
- verify that networks include all providers with whom the county is mandating MCOs to contract (i.e., public hospitals), and
- document any gaps in service area coverage that the must be filled pursuant to awarding a contract.

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