



## New York

2

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

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.  
 Provided:     No limitations     With limitations\*     Not provided
- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. (Limited to federal requirements under 1905(a) per section 1905(r) per PM 90-2.)
- 4.c.i. Family planning services and supplies for individuals of child-bearing age and for individuals eligible pursuant to Attachments 2.2-A and 2.2-B, if this eligibility option is elected by the State.  
 Provided:     No limitations     With limitations\*     Not provided
- 4.c.ii. Family planning-related services provided under the above State Eligibility Option.  
 Provided:     No limitations     With limitations\*
- 4.c.iii. Fertility services for women ages 21 through 44  
 Provided:     No limitations     With limitations\*  
 \*Limited to the provision of office visits, hysterosalpingogram services, pelvic ultrasounds, and blood testing for women in the process of ovulation enhancing drugs.
- 4.d.1. **Face-to-Face Counseling Services provided:**  
 (i) By or under supervision of a physician;  
 (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or  
 (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (none are designated at this time)
- 4.d.2. **Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women**  
 Provided:     No limitations     With limitations\*  
 [\*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period should be explained below.]  
 All Medicaid recipients, including pregnant women, receiving tobacco cessation counseling services can receive these services without any limitation [as stated above].

Please describe any limitations: 

\* Description provided on attachment.

TN #20-0021Approval Date May 1, 2020Supersedes TN #17-0058Effective Date April 1, 2020

New York  
2.1

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

**5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.**

Provided:    No limitations    With limitations\*    Not provided

**i. Lactation counseling services.**

Provided:    No limitations    With limitations\*    Not provided

**5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).**

Provided:    No limitations    With limitations\*    Not provided

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

**a. Podiatrists' services.**

Provided:    No limitations    With limitations\*    Not provided

\*Description provided on attachment.

TN   #13-10  

Approval Date   November 6, 2013  

Supersedes TN   NEW  

Effective Date   October 1, 2013

New York  
2a

**List of Available Organ Transplants** - categorically needy

- heart - bone - heart/lung
- kidney - skin - bone marrow
- liver - cornea

TN #91-39

Supersedes TN NEW

Approval Date February 18, 1992

Effective Date July 1, 1991

New York  
3

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

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

b. Optometrists' services.

Provided:             No limitations             With limitations \*

c. Chiropractors' services. (EPSDT only.)

Provided:             No limitations             With limitations \*

Not Provided.

d. Other practitioners' services.

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

Not Provided.

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

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

Not Provided.

(ii). Licensed Clinical Social Worker (LCSW)

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

Not Provided.

(iii). Licensed Mental Health Counselor (LMHC) and Licensed Marriage  
and Family Therapists (LMHT)

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

Not Provided.

7. Home health services.

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

Provided:             No limitations             With limitations \*

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

Provided:             No limitations             With limitations \*

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

Provided:             No limitations             With limitations \*

\* Description provided on attachment.

TN       #24-0034      

Approval Date       May 1, 2024      

Supersedes TN       #22-0043      

Effective Date       January 1, 2024

New York  
3a

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

**d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation therapy.**

Provided:             No limitations       With limitations \*

Not provided

**8. Private duty nursing services.**

Provided:             No limitations       With limitations \*

Not provided

\* Description provided on attachment.

TN   #91-75  

Approval Date   March 3, 1992  

Supersedes TN   NEW  

Effective Date   October 1, 1991

New York  
4

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

**9. Clinic services.**

Provided:             No limitations             With limitations \*  
 Not provided.

**10. Dental services.**

Provided:             No limitations             With limitations \*  
 Not provided.

**11. Physical therapy and related services.**

**a. Physical Therapy**

Provided:             No limitations             With limitations  
\*  Not provided.

**b. Occupational Therapy**

Provided:             No limitations             With limitations  
\*  Not provided.

**c. Services for individuals with speech, hearing, and language disorders  
(provided by or under the supervision of a speech pathologist or audiologist).**

Provided:             No limitations             With limitations  
\*  Not provided.

\* Description provided on attachment.

TN #20-0066  
Supersedes TN #91-52

Approval Date December 16, 2020  
Effective Date October 1, 2020

New York  
5

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

**12. Prescribed drugs, dentures, and prosthetic devices: and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.**

**a. Prescribed drugs.**

Provided:             No limitations             With limitations \*  
 Not provided.

**b. Dentures.**

Provided:             No limitations             With limitations \*  
 Not provided.

**c. Prosthetic devices.**

Provided:             No limitations             With limitations \*  
 Not provided.

**d. Eyeglasses.**

Provided:             No limitations             With limitations \*  
 Not provided.

**13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.**

**a. Diagnostic services.**

Provided:             No limitations             With limitations \*  
 Not provided.

\* Description provided on attachment.

TN   #93-49  

Approval Date   March 8, 1995  

Supersedes TN   #85-30  

Effective Date   September 1, 1993

New York  
6

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

**b. Screening services.**

Provided:             No limitations             With limitations \*  
 Not provided.

**c. Preventive services.**

Provided:             No limitations             With limitations \*  
 Not provided.

**d. Rehabilitative services.**

Provided:             No limitations             With limitations \*  
 Not provided.

**14. Services for individuals under 65 or older in institutions for mental diseases.**

**a. Inpatient hospital services.**

Provided:             No limitations             With limitations \*  
 Not provided.

**b. Skilled nursing facility services.**

Provided:             No limitations             With limitations \*  
 Not provided.

**c. Intermediate care facility services.**

Provided:             No limitations             With limitations \*  
 Not provided.

\* Description provided on attachment.

TN   #93-49    
Supersedes TN   #92-10  

Approval Date   March 8, 1995    
Effective Date   September 1, 1993

## New York

7

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

**15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.**

Provided:     No limitations     With limitations\*     Not provided

**b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.**

Provided:     No limitations     With limitations\*     Not provided

**16. Inpatient psychiatric facility services for individuals under 22 years of age.**

Provided:     No limitations     With limitations\*     Not provided

**17. Nurse-midwife services.**

Provided:     No limitations     With limitations\*     Not provided

**i. Lactation counseling services.**

Provided:     No limitations     With limitations\*     Not provided

**18. Hospice care (in accordance with section 1905(o) of the Act).**

Provided:     No limitations     With limitations\*     Not provided

\* Description provided on attachment.

TN   #12-16  

Approval Date   December 28, 2012  

Supersedes TN   #86-30  

Effective Date   September 1, 2012

New York  
8

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

19. Case management services and Tuberculosis related services.

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Provided:                     With limitations

Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

Provided:                     With limitations

Not provided.

20. Extended services for pregnant women.

- a. Pregnancy-related and postpartum services for 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

Additional coverage ++

- b. Services for any other medical condition that may complicate pregnancy.

Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

\* Description provided on attachment

TN #94-39

Approval Date November 23, 1994

Supersedes TN #94-14

Effective Date January 1, 1994





New York  
10

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

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

Provided  Not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded on institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, (C) furnished in a home.

Provided  State Approved (Not Physician) Service Plan Allowed

Services Outside the Home Also Allowed

Limitations Described on Attachment

Not provided

27. Primary Care Case Management

Provided  Not provided

TN #00-43

Approval Date March 28, 2001

Supersedes TN #94-49

Effective Date October 1, 2000

## COVERED SERVICES FOR PREGNANT WOMEN

	Presumptive Eligibility		Ongoing Medicaid Eligibility		
	≤ 100 %	≤ 200 %	MA	≤ 100 %	≤ 200 %
Description	Presumptively Eligible – Prenatal A	Presumptively Eligible – Prenatal B	Fully Eligible	Fully Eligible	Perinatal Care*
WMS Coverage Code	13	14	01	01	15
Individual Cat. Code	36	36	42	43	43
<b>Included Services</b>	Physician Care Midwife Care Outpatient Clinic/ Ambulatory Surgery Pharmacy/Supplies Dental Laboratory Laboratory/"X-ray" Eye Care Transportation Home Health Care Personal Care Nursing Services Personal Care Nursing Services Physical Therapy Occupational Therapy Speech Therapy Durable Med. Equip. Abortion Clinical Psychology Outpatient/Mental Health Outpatient/Alcoholism Health Education Nutritional Counseling Family Planning <u>Lactation Counseling</u>	Physician Care Midwife Care Outpatient Clinic Pharmacy Dental Laboratory Transportation Home Health Care Personal Care Nursing Services Clinical Psychology Outpatient/Mental Health Outpatient/Alcoholism Health Education Nutritional Counseling Family Planning <u>Lactation Counseling</u>	Physician Care Midwife Care Outpatient Clinic Pharmacy Dental Laboratory Eye Care Transportation Home Health Care Personal Care Nursing Services Physical Therapy Occupational Therapy Speech Pathology Durable Med. Equip. Abortion Clinical Psychology Outpatient/Mental Health Outpatient/Alcoholism Health Education Nutritional Counseling Family Planning Hospice Inpatient Care Alternate Level Care Institutional LTC <u>Lactation Counseling</u>	Physician Care Midwife Care Outpatient Clinic Pharmacy Dental Laboratory Eye Care Transportation Home Health Care Personal Care Nursing Services Physical Therapy Occupational Therapy Speech Pathology Durable Med. Equip. Abortion Clinical Psychology Outpatient/Mental Health Outpatient/Alcoholism Health Education Nutritional Counseling Family Planning Hospice Inpatient Care Alternate Level Care Institutional LTC <u>Lactation Counseling</u>	Physician Care Midwife Care Outpatient Clinic Pharmacy Dental Laboratory Transportation Home Health Care Personal Care Nursing Services Clinical Psychology Outpatient/Mental Health Outpatient/Alcoholism Health Education Nutritional Counseling Family Planning Inpatient Care <u>Lactation Counseling</u>
<b>Excluded Services</b>	Inpatient Care Alternate Level Care Institutional LTC LT Home Health Care	Inpatient Care Alternate Level Care Institutional LTC Podiatry Eye Care Durable Med. Equip. Abortion Physical Therapy Occupational Therapy Speech Pathology Hospice LT Home Health Care	None	None	Alternate Level Care Institutional LTC Eye Care Durable Med. Equip. Abortion Physical Therapy Occupational Therapy Speech Pathology Hospice LT Home Health Care

\*Pregnant women enrolled in a managed care plan, regardless of income level, will receive the full managed care service package without exclusions.  
A full listing of services is available from each managed care plan.

New York  
11

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

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

**Election of PACE:** By virtue of this submittal, the State elects PACE as an option State Plan service.

**No election of PACE:** By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

TN   #02-01    
Supersedes TN   NEW  

Approval Date   September 3, 2002    
Effective Date   January 1, 2002

New York  
11(a)

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

**28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers**

Provided:     No limitations     With limitations     None licensed or approved

Please describe any limitations:

**28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center**

Provided:     No limitations     With limitations (please describe below)  
 Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

- (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).
- (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). \*
- (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).\*

\*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

TN <u>#13-27</u>	Approval Date <u>February 4, 2015</u>
Supersedes TN <u>NEW</u>	Effective Date <u>October 1, 2013</u>

New York  
12

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

**29. Physician's assistants.**

Provided:             No limitations             With limitations\*     Not provided

**a. Lactation counseling services.**

Provided:             No limitations             With limitations\*     Not provided

**30. Registered Nurses.**

Provided:             No limitations             With limitations\*     Not provided

**a. Lactation counseling services.**

Provided:             No limitations             With limitations\*     Not provided

\* Description provided on attachment.

TN #12-16  
Supersedes TN NEW

Approval Date December 28, 2012  
Effective Date September 1, 2012