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State/Territory: New York

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY  
GROUP (S): \_\_\_\_\_

The following ambulatory services are provided.

\* Description provided on attachment.

TN #86-30

Approval Date September 11, 1990

Supersedes TN #82-9

Effective Date October 1, 1986

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**AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES  
PROVIDED TO THE MEDICALLY NEEDED**

1. Inpatient hospital services other than those provided in an institution for mental diseases.  
 Provided:             No limitations             With limitations\*
2. a. Outpatient hospital services.  
 Provided:             No limitations             With limitations\*
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.  
 Provided:             No limitations             With limitations\*     Not provided.
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).  
 Provided:             No limitations             With limitations\*
- d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.  
 Provided:             No limitations             With limitations\*
3. Other laboratory and x-ray services.  
 Provided:             No limitations             With limitations\*
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\*
- 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.)  
 Provided:             No limitations             With limitations\*     Not provided.
- c.i. Family planning services and supplies for individuals of childbearing 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\*
- c.ii. Family planning-related services provided under the above State Eligibility Option.  
 Provided:             No limitations             With limitations\*

\*Description provided on attachment.

- 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.

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AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
TO THE MEDICALLY NEEDY

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:

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

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

\* Description provided on attachment

TN #13-10

Approval Date November 6, 2013

Supersedes TN #12-16

Effective Date October 1, 2013

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List of Available Organ Transplants – medically needy

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

TN #91-39  
Supersedes TN NEW

Approval Date February 18, 1992  
Effective Date July 1, 1991







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State/Territory:     New York    

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY  
GROUP (S): \_\_\_\_\_

c. Intermediate care facility services.

Provided:             No limitations         With limitations \*         Not provided.

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.

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

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**AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S):**

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:     No limitations     With limitations\*     Not provided
- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.
- Provided:     No limitations     With limitations\*     Not provided
20. Extended services for pregnant women.
- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60<sup>th</sup> day falls.
- Provided:<sup>+</sup>     No limitations     With limitations\*     Not provided  
 Additional coverage:<sup>++</sup>
- b. Services for any other medical conditions that may complicate pregnancy.
- Provided:<sup>+</sup>     No limitations     With limitations\*     Not provided  
 Additional coverage:<sup>++</sup>    [ Not provided]
21. Certified pediatric or family nurse practitioners' services.
- Provided:     No limitations     With limitations\*     Not provided
- a. Lactation counseling services.
- Provided:     No limitations     With limitations\*     Not provided

<sup>+</sup> Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

<sup>++</sup> 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#: 12-16

Approval Date: December 28, 2012

Supersedes TN#: 94-39

Effective Date: September 1, 2012

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP (S):

\*22. Respiratory care services (in accordance with section 1902 (e) (9) (A) through (C) of the Act).

[ ] Provided: [ ] No limitations [ ] With limitations \*
[x] Not provided

\*23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

[x] Provided: [ ] No limitations [x] With limitations \*
[ ] Not provided

b. Services provided in Religious Nonmedical Health Care Institutions.

[ ] Provided: [ ] No limitations [ ] With limitations \*
[x] Not provided

c. Reserved

d. Nursing facility services for patients under 21 years of age.

[x] Provided: [ ] No limitations [x] With limitations \*
[ ] Not provided

e. Emergency hospital services.

[x] Provided: [ ] No limitations [x] With limitations \*
[ ] Not provided

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

[x] Provided: [ ] No limitations [x] With limitations \*
[ ] Not provided

\*Description provided on attachment.

TN #01-40 Approval Date February 8, 2002
Supersedes TN #87-47 #91-39 Effective Date January 1, 2002

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State/Territory:     New York    

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO MEDICALLY  
NEEDY GROUP (S):  
\_\_\_\_\_

- 24. 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

- 25. 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 or 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, and (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

- 26. Primary Care Case Management

Provided  Not Provided

TN     #00-43    

Approval Date     March 28, 2000    

Supersedes TN     NEW    

Effective Date     October 1, 2000

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Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy

27. 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 optional 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

Approval Date September 3, 2002

Supersedes TN NEW

Effective Date January 1, 2002

## 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*
<b>WMS Coverage Code</b>	<b>13</b>	<b>14</b>	<b>01</b>	<b>01</b>	<b>15</b>
<b>Individual Cat. Code</b>	<b>36</b>	<b>36</b>	<b>42</b>	<b>43</b>	<b>43</b>
<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 Physical Therapy Occupational Therapy Speech Therapy Durable Med. Equip. Abortion Clinical Psychology Outpatient/Mental Health Outpatient/Alcoholism Health Education Nutritional Counseling Family Planning Lactation Counseling	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 Lactation Counseling	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 Lactation Counseling	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 Lactation Counseling	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 Lactation Counseling
<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.

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

28. Physician's assistants.

Provided:             No limitations             With limitations\*     Not provided

a. Lactation counseling services.

Provided:             No limitations             With limitations\*     Not provided

29. 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 Approval Date: December 28, 2012

Supersedes TN#: NEW Effective Date: September 01, 2012

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**AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES  
PROVIDED TO THE MEDICALLY 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 #13-27

Supersedes TN NEW

Approval Date February 4, 2015

Effective Date October 1, 2013