

New York
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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 NEEDY**

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

**New York
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List of Available Organ Transplants – medically 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
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State/Territory: New York

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

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

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

a. Podiatrists' Services

☒ Provided: ☐ No limitations ☒ With limitations*

b. Optometrists' Services

☒ Provided: ☐ No limitations ☒ With limitations*

c. Chiropractors' Services

☒ 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 service 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*

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

☐ Provided ☒ No limitations ☐ With limitations

*Description provided on attachment.

TN #24-0034

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State/Territory: New York

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

8. Private duty nursing services.

[x] Provided: [] No limitations [x] With limitations *

9. Clinical services.

[x] Provided: [] No limitations [x] With limitations *

10. Dental services.

[x] Provided: [] No limitations [x] With limitations *

11. Physical therapy and related services.

a. Physical therapy.

[x] Provided: [X] No limitations [[X]] With limitations *

b. Occupational therapy.

[x] Provided: [X] No limitations [[X]] With limitations *

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

[x] Provided: [X] No limitations [[X]] With limitations *

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.

[x] Provided: [] No limitations [x] With limitations *

b. Dentures.

[x] Provided: [] No limitations [x] With limitations *

*Description provided on attachment.

TN **#20-0066**

Approval Date **December 16, 2020**

Supersedes TN **#91-52**

Effective Date **October 1, 2020**

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State/Territory: New York

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

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations *

d. Eyeglasses.

☒ Provided: ☐ No limitations ☒ With limitations *

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

a. Diagnostic services.

☒ Provided: ☐ No limitations ☒ With limitations *

b. Screening services.

☒ Provided: ☐ No limitations ☒ With limitations *

c. Preventive services.

☒ Provided: ☐ No limitations ☒ With limitations *

d. Rehabilitative services.

☒ Provided: ☐ No limitations ☒ With limitations *

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

a. Inpatient hospital services.

☒ Provided: ☒ No limitations ☐ With limitations *

b. Skilled nursing facility services.

☐ Provided: ☐ No limitations ☐ With limitations *

*Description provided on attachment.

TN #93-49

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Effective Date September 1, 1993

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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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[State/Territory: New York]

**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 60th day falls.

☒ Provided:⁺ ☐ No limitations ☐ With limitations* ☐ Not provided
☐ Additional coverage:⁺⁺

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

☒ Provided:⁺ ☐ No limitations ☐ With limitations* ☐ Not provided
☐ Additional coverage:⁺⁺ [☐ 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

⁺ 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.

⁺⁺ 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

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Supersedes TN#: 94-39

Effective Date: September 1, 2012

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State/Territory: New York

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 *
☒ Not provided

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

- a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations *
☐ Not provided

- b. Services provided in Religious Nonmedical Health Care Institutions.

☐ Provided: ☐ No limitations ☐ With limitations *
☒ Not provided

- c. Reserved

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

☒ Provided: ☐ No limitations ☒ With limitations *
☐ Not provided

- e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ 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.

☒ Provided: ☐ No limitations ☒ 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 YorkAMOUNT, 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 ProvidedTN #00-43Approval Date March 28, 2000Supersedes TN NEWEffective 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

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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* |
| WMS Coverage Code | 13 | 14 | 01 | 01 | 15 |
| Individual Cat. Code | 36 | 36 | 42 | 43 | 43 |
| Included Services | 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 Clinical Psychology Outpatient/Mental Health Outpatient/Alcoholism Health Education 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 |
| Excluded Services | 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

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