Table of Contents

State/Territory Name: New York

State Plan Amendment (SPA) #: 18-0006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
New York Regional Office
26 Federal Plaza, Room 37-100
New York, NY 10278

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATION

May 8, 2018

Donna Frescatore
State Medicaid Director
Office of Health Insurance Programs
NYS Department of Health
One Commerce Plaza/99 Washington Avenue
Suite 1211
Albany, New York 12210

RE: #18-0006

Dear Ms. Frescatore:

This is to notify you that New York's State Plan Amendment (SPA) #18-0006, "Medically Needy Income Levels," has been approved for adoption into the State Medicaid Plan with an effective date of January 1, 2018. This SPA proposes to modify the eligibility levels for the Medicaid program to reflect the revised income figures for Medically Needy households. This adjustment provides the basis for estimating revisions used in determining Medicaid eligibility.

If you have any questions or wish to discuss this SPA further, please contact Michael Cutler of this office. Mr. Cutler may be reached at (212) 616-2421.

Sincerely,

[redacted]

Michael Melendez, LMSW
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Nicole McKnight
Maria Tabakov
Mike Cutler

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **18-0006**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **January 1, 2018**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **§1902(a)(10)(C)(i)(III) of the Social Security Act** **§1905(w) of the Social Security Act**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 01/01/18-09/30/18 $ 0** **b. FFY 10/01/18-09/30/19 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Supp 1 to Att 2.6-A: Pages 8, 9**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Supp 1 to Att 2.6-A: Pages 8, 9**

10. SUBJECT OF AMENDMENT:
2018 Revisions to Medically Needy Income Levels (FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: **New York State Department of Health** **Bureau of Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: MAR 1 3 2018	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: **MAY 08, 2018**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **JANUARY 01, 2018**	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: **MICHAEL MELENDEZ**	22. TITLE: **DIVISION OF MEDICAID & CHILDRENS HEALTH**

23. REMARKS:

OR

FORM HCFA-179 (07-92)

New York
8

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

Income Levels (Continued)

D. Medically Needy

__X__ Applicable to all groups.

____ Applicable to all groups except those specified below. Excepted group income levels are also listed on the attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for ____ months. _____ Urban Only _____ Urban & Rural	Amount by which column (2) exceeds limits specified in 42 CFR 435.1007	Net income for persons living in rural areas for ____ months.	Amount by which column (4) exceeds limits specified 42 CFR 435.1007
1	$ [9,900] 10,100	$	$	$
2	$[14,500] 14,800	$	$	$
3	$[16,675] 17,020	$	$	$
4	$[18,850] 19,240	$	$	$

New York
9

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

Income Levels (Continued)

D. Medically Needy

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for ____ months. ____Urban Only ____Urban & Rural	Amount by which column (2) exceeds limits specified in 42 CFR 435.1007	Net income for persons living in rural areas for ___ months.	Amount by which column (4) exceeds limits specified in 42 CFR 435.1007
5	$[21,025] 21,460	$	$	$.
6	$[23,200] 23,680	$	$	$.
7	$[25,375] 25,900	$	$	$.
8	$[27,550] 28,120	$	$	$.
9	$[29,725] 30,340	$	$	$.
10	$[31,900] 32,560	$	$	$.
For each additional Person add	$[2,175] 2,220	$	$	$.