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State/Territory Name: New York

State Plan Amendment (SPA) #: 17-0050

This file contains the following documents in the order listed:

1) Approval Letter

2) CMS 179 Form

3) Approved SPA Pages

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 OPERATIONS

DMCHO: MT: SPA NY-17-0050

September 19, 2017

Jason Helgerson
Deputy Commissioner
Office of Health Insurance Programs
New York State Department of Health
Corning Tower (OCP-1211)
Albany, New York 12237

Dear Mr. Helgerson:

This is to notify you that New York State Plan Amendment (SPA) #17-0050 has been approved for adoption into the State Medicaid Plan with an effective date of June 1, 2017. This State Plan Amendment amends the Community First Choice Option conflict of interest (COI) language invoking the geographical exemption to the COI requirements.

Enclosed are copies of the approved SPA # 17-0050. If you have any questions or wish to discuss this SPA further, please contact Maria Tabakov. Ms. Tabakov may be reached at (212) 616-2503.

Sincerely,

[redacted]

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

cc: R. Deyette
M. Levesque

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: **17-0050**	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 **June 1, 2017**	

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: **42 CFR 441.555(c)(5)**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 06/01/17-09/30/17 $ 0** **b. FFY 10/01/17-09/30/18 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 3.1-K – Supplement – Page 8; 9; 9.1; 9.2**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 3.1-K – Supplement – Page 8; 9**

10. SUBJECT OF AMENDMENT:
Community First Choice Option
(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** **Division of Finance & Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1432** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: JUN 29 2017	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: **SEPTEMBER 19, 2017**
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: **JUNE 01, 2017**	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: **MICHAEL MELENDEZ**	22. TITLE: **TRATOR** **DIVISION OF MEDICAID & CHILDREN'S HEALTH**

23. REMARKS:

FORM HCFA-179 (07-92)

State Plan under Title XIX of the Social Security Act
State/Territory: New York

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

k) Reassessment and review schedules;

l) Defining goals, needs and preferences;

m) Identifying and accessing services, supports and resources;

n) Development of risk management agreements;

o) Development of personalized backup plan;

p) Recognizing and reporting critical events, including abuse investigations; and

q) Information about advocates or advocacy systems and how to access advocates and advocacy systems.

Conflict of Interest Standards

The State will ensure that the individuals conducting the functional needs assessment and person-centered SP for CFCO participants are not:

a) A parent or spouse of the individual, or to any paid caregiver of the individual.

b) Financially responsible for the individual.

c) Empowered to make financial or health-related decisions on behalf of the individual.

d) Individuals who would benefit financially from the provision of assessed needs and services.

e) Providers of State Plan HCBS for the individual, or those who have an interest in or are employed by a provider of State Plan HCBS for the individual. [unless the CFCO recipient chooses to receive State Plan HCBS services from the same agency as employs the Care Coordinator who develops the SP.] The State invokes the Conflict of Interest Exception when the only willing and qualified entity performing assessments of functional need and/or developing the person-centered service plan also provide home and community-based services.

Firewalls exist in both the FFS and MC/MLTC environments. First, standardized assessments determine the individual recipient's level of care and functional needs. In addition, all recipients of personal care are required to have a doctor's order establishing the need to address specific ADLs, IADLs and health-related tasks. These protections ensure that objective criteria inform the service plan for individuals participating in the Community First Choice Option.

State Plan under Title XIX of the Social Security Act
State/Territory: New York

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

Additional firewalls help the State ensure that those conducting the functional needs assessment and person-centered SP for CFCO participants do so independent of those providing services. In many cases under the managed care model, this is assured through managed care entities contracting out for services. By sub-contracting out for the provision of CFCO services and supports, such as personal care, the managed care organization remains conflict-free by only conducting the functional needs assessment and developing the person-centered SP with the consumer. [Where this is not the practice, and the Service Coordinator or assessor works for the Plan, the State will assure that there is separation of the roles between the Coordinator and other duties at the provider agency accordingly:

- The Service Coordinator will not be employed as a CFCO direct care worker at the provider agency;
- The Service Coordinator will not have the authority to authorize CFCO services except on a temporary basis where presumed eligibility is permitted (not to exceed 29 days); and
- The Service Coordinator will not have a majority ownership stake in the provider agency.]
- In the FFS environment, the Local Department of Social Services (LDSS) will assure that there is separation between the function as Coordinator or assessor and the other functions the same individual performs at the LDSS or agency/provider. Firewalls ensure that the individual conducting the functional needs assessment and/or developing the person-centered SP is independent of those who are providing the services. Accordingly, the Coordinator or assessor will not:
    - provide services as a CFCO direct care worker for the CFCO consumer; nor
    - have a majority ownership stake in the provider agency.

In all cases, service recipients are made aware of appeals processes and due process protections to assure their needs are met in the fairest manner possible.

[Providers: Service Coordinators have a masters of social work or psychology, are a registered professional nurse, or a licensed or certified teacher, rehabilitation counselor and/or therapist with a minimum of one year of experience providing service coordination and information, linkages and referrals to the elderly and/or disabled regarding community based services or an individual with a bachelor's degree and two years of related experience or someone with none of the educational requirements with three years of related experience. Individuals who do not meet the requirements may be supervised by those who meet both experience and educational requirements.

Care Managers typically have a background in nursing, social work and/or human services. Case Managers have similar backgrounds and the title is used interchangeably.

Risk Management Plans

An in-person risk assessment is conducted for all individuals during the person-centered care planning process. Based on the results of the risk assessment, a risk management plan is developed for each individual and is detailed in the SP.

Safeguards are supports needed to keep the participant safe from risk and harm and actions to be taken when the health or welfare of the participant is at risk.]

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In the FFS environment, consumers are informed of their Medicaid Fair Hearing Rights with any Notice of Decision, including denial of their application, denial of requested provider, reduction in services, or termination from the waiver. An informal discussion (Administrative Meeting) is also offered to explain the reasoning behind a decision and negotiate an agreement prior to the Fair Hearing.

In the Managed Care environment, members are also informed of their Medicaid Fair Hearing Rights. In addition, Managed Care Organizations are contractually obligated to provide its members with a grievance system. The Grievance System regulations in Subpart F of 42 CFR Part 438 apply to both "expressions of dissatisfaction" by Enrollees (grievances) and to requests for a review of an "action" (as defined in 438.400) by a managed long term care plan (an appeal). For managed care plans, the Grievance System processes identified in Subpart F have been combined with the grievance requirements in New York State Public Health Law (PHL) 4408-a and the utilization review and appeal requirements in Article 49 of the PHL.

The State provides direct oversight of the Managed Care plans and the LDSSs to ensure that all conflicts are avoided and firewalls are in place. It is the responsibility of the Managed Care plans and the LDSSs to ensure that there are appropriate firewalls in place between the entity that is developing the plan of care and the entity providing the services.

In the fee-for-service and managed care environments, the state monitors service plan development through surveillance efforts that are aimed at identifying non-compliance with State mandates. These efforts include the ongoing review of a sample of person-centered service plans, on-site LDSS audits, and routine monitoring of the quality assurance and performance improvement program that both Managed Care plans and the LDSSs must develop, receive state approval, and successfully implement. Plans and LDSSs are expected to comply with all State mandates.

If the State identifies deficiencies in service plan development by the managed care organizations, the plans will be subject to actions that include but are not limited to, statements of deficiency and corrective action plans.

If the State identifies deficiencies in service plan development by the LDSSs, the local districts will receive notices of deficiency and will be subject to actions that include but are not limited to, statements of deficiency and corrective action plans.

In all occurrences of inadequacies and/or deficiencies in service plan development, the State will conduct a follow up training on person-centered service planning to ensure compliance going forward.

Providers: Service Coordinators have a masters of social work or psychology, are a registered professional nurse, or a licensed or certified teacher, rehabilitation counselor and/or therapist with a minimum of one year of experience providing service coordination and information, linkages and referrals to the elderly and/or disabled regarding community based services or an individual with a

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