



Department of Health

ANDREW M. CUOMO
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Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

JUN 29 2017

RE: SPA #17-0050
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #17-0050 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective June 1, 2017 (Appendix I). This amendment is being submitted based on federal regulation. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with and promote efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by §1902(a)(30) of the Social Security Act and 42 CFR §447.204.

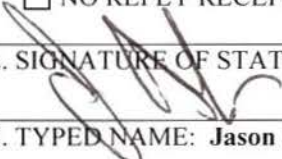
Copies of pertinent sections of federal regulation are enclosed for your information (Appendix III). In addition, responses to the five standard funding questions are also enclosed (Appendix IV).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 474-6350.

Sincerely,

Jason A. Helgeson
Medicaid Director
Office of Health Insurance Programs

Enclosures

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 (<i>Check One</i>): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
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. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 3.1-K – Supplement – Page 8	
10. SUBJECT OF AMENDMENT: Community First Choice Option (FMAP = 50%)			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		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:	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

Appendix I
2017 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

**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.] 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. Federal regulations provide an exception to this conflict of interest requirement when there have been diligent efforts to identify that the only willing and qualified entity/entities to perform the functional needs assessment and/or develop the SP in a geographic area, such as in rural areas, are also providers of HCBS.

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.

TN #17-0050 _____

Approval Date _____

Supersedes TN #13-0035 _____

Effective Date _____

Appendix II
2017 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #17-0050

This State Plan Amendment proposes to amend the Conflict of Interest language to include the geographic exception language and describe the firewalls in place to comply with the regulation. This SPA amends the section identified by CMS to bring the State into compliance with the COI requirement.

Appendix III
2017 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

Centers for Medicare & Medicaid Services, HHS

§ 441.555

(4) Evaluating attendant care providers' performance.

(e) Determining the amount paid for a service, support, or item, in accordance with State and Federal compensation requirements.

(f) Reviewing and approving provider payment requests.

§ 441.555 Support system.

For each service delivery model available, States must provide, or arrange for the provision of, a support system that meets all of the following conditions:

(a) Appropriately assesses and counsels an individual before enrollment.

(b) Provides appropriate information, counseling, training, and assistance to ensure that an individual is able to manage the services and budgets if applicable.

(1) This information must be communicated to the individual in a manner and language understandable by the individual. To ensure that the information is communicated in an accessible manner, information should be communicated in plain language and needed auxiliary aids and services should be provided.

(2) The support activities must include at least the following:

(i) Person-centered planning and how it is applied.

(ii) Range and scope of individual choices and options.

(iii) Process for changing the person-centered service plan and, if applicable, service budget.

(iv) Grievance process.

(v) Information on the risks and responsibilities of self-direction.

(vi) The ability to freely choose from available home and community-based attendant providers, available service delivery models and if applicable, financial management entities.

(vii) Individual rights, including appeal rights.

(viii) Reassessment and review schedules.

(ix) Defining goals, needs, and preferences of Community First Choice services and supports.

(x) Identifying and accessing services, supports, and resources.

(xi) Development of risk management agreements.

(A) The State must specify in the State Plan amendment any tools or instruments used to mitigate identified risks.

(B) States utilizing criminal or background checks as part of their risk management agreement will bear the costs of such activities.

(xii) Development of a personalized backup plan.

(xiii) Recognizing and reporting critical events.

(xiv) Information about an advocate or advocacy systems available in the State and how an individual can access the advocate or advocacy systems.

(c) Establishes conflict of interest standards for the assessments of functional need and the person-centered service plan development process that apply to all individuals and entities, public or private. At a minimum, these standards must ensure that the individuals or entities conducting the assessment of functional need and person-centered service plan development process are not:

(1) Related by blood or marriage to the individual, or to any paid caregiver of the individual.

(2) Financially responsible for the individual.

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

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

(5) 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, except when the State demonstrates that the only willing and qualified entity/entities to perform assessments of functional need and develop person-centered service plans in a geographic area also provides HCBS, and the State devises conflict of interest protections including separation of assessment/planning and HCBS provider functions within provider entities, which are described in the State plan, and individuals are provided with a clear and accessible alternative dispute resolution process.

§ 441.560

(d) Ensures the responsibilities for assessment of functional need and person-centered service plan development are identified.

§ 441.560 Service budget requirements.

(a) For the self-directed model with a service budget, a service budget must be developed and approved by the State based on the assessment of functional need and person-centered service plan and must include all of the following requirements:

(1) The specific dollar amount an individual may use for Community First Choice services and supports.

(2) The procedures for informing an individual of the amount of the service budget before the person-centered service plan is finalized.

(3) The procedures for how an individual may adjust the budget including the following:

(i) The procedures for an individual to freely adjust amounts allocated to specific services and supports within the approved service budget.

(ii) The circumstances, if any, that may require prior approval by the State before a budget adjustment is made.

(4) The circumstances, if any, that may require a change in the person-centered service plan.

(5) The procedures that govern the determination of transition costs and other permissible services and supports as defined at § 441.520(b).

(6) The procedures for an individual to request a fair hearing under Subpart E of this title if an individual's request for a budget adjustment is denied or the amount of the budget is reduced.

(b) The budget methodology set forth by the State to determine an individual's service budget amount must:

(1) Be objective and evidence-based utilizing valid, reliable cost data.

(2) Be applied consistently to individuals.

(3) Be included in the State plan.

(4) Include a calculation of the expected cost of Community First Choice services and supports, if those services and supports are not self-directed.

(5) Have a process in place that describes the following:

42 CFR Ch. IV (10-1-15 Edition)

(i) Any limits the State places on Community First Choice services and supports, and the basis for the limits.

(ii) Any adjustments that are allowed and the basis for the adjustments.

(c) The State must have procedures in place that will provide safeguards to individuals when the budgeted service amount is insufficient to meet the individual's needs.

(d) The State must have a method of notifying individuals of the amount of any limit that applies to an individual's Community First Choice services and supports. Notice must be communicated in an accessible format, communicated in plain language, and needed auxiliary aids and services should be provided.

(e) The budget may not restrict access to other medically necessary care and services furnished under the State plan and approved by the State but which are not included in the budget.

(f) The State must have a procedure to adjust a budget when a reassessment indicates a change in an individual's medical condition, functional status, or living situation.

§ 441.565 Provider qualifications.

(a) For all service delivery models:

(1) An individual retains the right to train attendant care providers in the specific areas of attendant care needed by the individual, and to have the attendant care provider perform the needed assistance in a manner that comports with the individual's personal, cultural, and/or religious preferences.

(2) An individual retains the right to establish additional staff qualifications based on the individual's needs and preferences.

(3) Individuals also have the right to access other training provided by or through the State so that their attendant care provider(s) can meet any additional qualifications required or desired by individuals.

(b) For the agency-provider model, the State must define in writing adequate qualifications for providers in the agency model of Community First Choice services and supports.

(c) For the self-directed model with service budget, an individual has the option to permit family members, or

Appendix IV
2017 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #17-0050

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of the state plan. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

- 1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).**

Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
- (i) a complete list of the names of entities transferring or certifying funds;**
 - (ii) the operational nature of the entity (state, county, city, other);**
 - (iii) the total amounts transferred or certified by each entity;**
 - (iv) clarify whether the certifying or transferring entity has general taxing authority; and,**
 - (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

Response: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

The source of the appropriation is the Local Assistance Account under the General Fund/Aid to Localities.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

Response: The payments authorized for this provision are not supplemental or enhanced payments.

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper**

payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

Response: Not applicable. State expenditures under the Community First Choice Option are to be made for attendant services and related supports provided exclusively in home and community based settings.

- 5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

Response: No, not applicable.

ACA Assurances:

- 1. Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

MOE Period.

- **Begins on: March 10, 2010, and**
- **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

- 2. Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31,

2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

Response: This SPA would [] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

3. Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Response: The State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

- a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
- b) Please include information about the frequency inclusiveness and process for seeking such advice.**
- c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.