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State/Territory Name: New York

State Plan Amendment (SPA) #: 18-0058

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 FIELD OPERATIONS EAST

February 28, 2019

Donna Frescatore
State Medicaid Director
New York State Department of Health
Office of Health Insurance Programs
One Commerce Plaza, Suite 1211
Albany, NY 12237

Dear Ms. Frescatore:

The Centers for Medicare & Medicaid Services (CMS) has approved your request to adopt New York's State Plan Amendment (SPA) #18-0058, Office for People With Developmental Disabilities (OPWDD) Medicaid Service Coordination (MSC) - Basic Home and Community Based Services (HCBS) Plan Support, into the State Medicaid Plan with an effective date of July 1, 2018. This SPA implements changes to sunset provisions of SPA 12-0030 pertaining to the MSC Program, and puts into place the Basic HCBS Plan Support as an alternative for those persons electing not to enroll in a Care Coordination Organization/Health Home (CCO/HH) for the comprehensive Care Management option. This SPA also prescribes provider qualifications for the provision of the Basic HCBS Plan Support benefit.

We would like to express our gratitude for the effort and cooperation provided by your staff during our review of your amendment request. If you have any questions on this matter, please contact Christopher Semidey at (212) 616-2328 or Christopher.Semidey@cms.hhs.gov.

Sincerely,

Nicole McKnight
Acting Deputy Director
Division of Medicaid Field Operations East

cc: Christopher.Semidey@cms.hhs.gov
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 0058

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 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
§1915(g) of the Social Security Act

7. FEDERAL BUDGET IMPACT
a. FFY 07/01/18-09/30/18 $ 1,052.27
b. FFY 10/01/18-09/30/19 $ 2,024.64

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supp 1 Att 3.1-A - Page: 1-B.1, 1-B.2, 1-B.3, 1-B.4, 1-B.5, 1-B.6, 1-B.7
Att 4.19-B – Page 3(h.13)
Att 4.19-B – Page 3(h.14), Page 10-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supp1 Att 3.1-A - Page: 1-B.1,1-B.2,1-B.3,1-B.4,1-B.5,1-B.6, 1-B.7
Att 4.19-B – Page 3(h.13)
Att 4.19-B – Page 3(h.14), Page 10-2

10. SUBJECT OF AMENDMENT
OPWDD MSC
(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]

13. TYPED NAME
Donna Frescatore

14. TITLE
Medicaid Director, Department of Health

15. DATE SUBMITTED
September 28, 2018

16. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED
FEBRUARY 28, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
JULY 01, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
NICOLE MCKNIGHT

22. TITLE
Division of Medicaid Field Operations East

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

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

TARGETED CASE MANAGEMENT SERVICES
Target Group B – Medicaid Service Coordination (MSC)

Office of People With Development Disabilities (OPWDD) -
Individuals with Intellectual and Developmental Disabilities (II/DD)

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Persons enrolled in Medical Assistance who:

(1) Have a developmental disability as defined in New York Mental Hygiene Law §1.03, and

(2) Are in need of the support of Care Manager to assist in coordinating the Medicaid-funded Long Term Supports that the person receives or would benefit from receiving, and

(3) Have chosen to receive the services and not to receive comprehensive Health Home Care Management through the Health Home model, and

(4) Reside in their own or family home, live in an OPWDD certified residence (Individualized Residential Alternative, Community Residence or Family Care Home). However, persons who receive Basic Home and Community-Based Services (HCBS) Plan Support and are receiving institutional care reimbursed under the Medical Assistance Program may continue to receive Basic HCBS Plan Support for up to 30 days when persons are temporarily institutionalized, and when the admission to the institution is initially expected to be 30 days or less.

___ **Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 0 (zero) consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)**

Areas of State in which services will be provided (§1915(g)(1) of the Act):

X Entire State

___ Only in the following geographic areas: **[Specify areas]**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

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TARGETED CASE MANAGEMENT SERVICES
Target Group B – Medicaid Service Coordination (MSC)

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- **Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include**
  - **Gathering pertinent individual and family history;**
  - **identifying the individual's needs and completing related documentation; and**
  - **gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;**

Assessment activities include taking the person's history, identifying needs of the individual, and completing related documentation. It also includes gathering information from other sources such as family members, medical providers, clinical assessments, educators, and other individuals/providers associated with the person, if necessary, to form a complete assessment (i.e., picture) of the person and his/her needs and goals. Re-assessment should occur when the care plan (known as an Individualized Service Plan (ISP) or Life Plan) is reviewed semi-annually or more frequently if necessary based on the changing needs of the person or his or her request for a reassessment. The Care Manager may recommend an individual seek more comprehensive services through the Health Home model if the needs of the individual require more frequent reviews and re-assessments than is available under this option. Basic HCBS Plan Support provides care management and does not provide the comprehensive, core services available through the Health Home model. The individual may choose to enroll in the Health Home service at any time. A request to change from between Basic HCBS Plan Support and Health Home Care Management may be submitted to the OPWDD Development Disabilities Regional Office (DDRO) which can authorize the new service for the first date of the following month.

- **Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that**
  - **specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;**
  - **includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and**
  - **identifies a course of action to respond to the assessed needs of the eligible individual;**

- **Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and**

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TARGETED CASE MANAGEMENT SERVICES
Target Group B – Medicaid Service Coordination (MSC)

Office of People With Development Disabilities (OPWDD) -
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❖ **Monitoring and follow-up activities:**
- **activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:**
  - **services are being furnished in accordance with the individual's care plan;**
  - **services in the care plan are adequate; and**
  - **changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.**

This is the service provided by the Care Manager. It includes direct contacts on a bi-annual or up to a quarterly basis:
- Assessing the person's satisfaction with his or her supports and services as identified within the care plan, known as an ISP or Life Plan, and making adjustments as necessary;
- Supporting the person towards achievement of valued outcomes;
- Establishing and maintaining an effective communication network with service providers;
- Keeping up to date with changes, choices, temporary setbacks;
- Accomplishments relating to the persons supports and services as reflected in the ISP or Life Plan;
- Managing through difficulties or problems or crises as they occur;
- Assisting the person in assuring that his or her rights, protections and health and safety needs are met pursuant to state law and regulations;
- Keeping the ISP or Life Plan document current by adapting it to change; and
- Reviewing the ISP or Life Plan at least semi-annually.

X **Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.**

(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

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Effective 07/01/2018, provider organizations will be known as CCO/HH. The following are the general provider qualifications under the Health Home model:

- CCO/HH providers must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements and CCO/HH standards, requirements and guidance issued by the State.
- CCO/HH providers eligible to deliver Basic HCBS Plan Support must also be designated by NYSDOH and the OPWDD to deliver Health Home Care Management Services and Basic HCBS plan support.
- CCO/HH providers must also have:
    - the capacity to conduct IT-enabled planning services for the I/DD population; and
    - a Regional Network for referrals to developmental disability, health and behavioral health services.

Effective 07/01/2018, Care Managers will be regulated by the Health Home model. The following are the educational and experience qualifications a Care Manager employed by the CCO/HH:

1) A Bachelor's degree with two (2) years of relevant experience, OR
2) A License as a Registered Nurse with two (2) years or relevant experience, which can include any employment experience and is not limited to case management/service coordination duties OR
3) A Master's degree with one (1) year of relevant experience.

To support the transition to CCO/HH and Basic HCBS Plan Support services, the following special allowance is made for Care Managers who served as a MSC Service Coordinator and do not meet the above educational requirements.

1) Care Managers who served as an MSC Service Coordinators prior to July 1, 2018 are "grandfathered" to facilitate continuity for the individual receiving coordination. Documentation of the employee's prior status as an MSC Service Coordinator may include a resume or other record created by the MSC Agency or the CCO/HH demonstrating that the person was employed as an MSC Service Coordinator prior to July 1, 2018.
2) CCO/HHs will be required to provide the CCO/HH core services training for current MSC Service Coordinators transitioning to CCO/HH Care Management and who do not meet the minimum education and experience requirements. Such training will be provided by the CCO/HH within one (1) year of contracting with an MSC Service

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Coordinator. The CCO/HH will adjust training activities for Care Managers serving individuals enrolled in Basic HCBS Plan Support, but all Care Managers must be able to deliver both the Health Home Care Management service and Basic HCBS Plan Support.

Care Managers who serve Willowbrook Class members must be Qualified Intellectual Disabilities Professionals (QIDP).

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. **Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.**
2. **Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.**

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- **Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.**
- **Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and**
- **Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.**

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan

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have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
X Target group consists of eligible individuals with developmental disabilities. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

A CCO/HH is a Health Home that is tailored to meet the needs of individuals with intellectual and/or developmental disabilities (I/DD). CCO/HHs will be designated by the NYSDOH in collaboration with the NYS OPWDD. CCO/HHs and Care Managers provide person-centered care management, planning and coordination services that are tailored specifically to help people with I/DD and their families coordinate all services.

Effective 07/01/2018, entities must demonstrate they are controlled (at least 51 percent) by one or more non-profit organizations with a history of providing or coordinating developmental disability, health, and long-term care services to persons with II/DD, including MSC and/or I/DD long term supports and services (LTSS). New York State's expectation is that the governance structure and leadership of the I/DD Health Home (board members and officers) will have extensive experience coordinating care for individuals with I/DD in New York State; prior experience in overseeing and operating entities that have delivered MSC or I/DD HCBS waiver services to individuals with I/DD, and are in good standing with the State.

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §44[1]0.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §44[1]0.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing

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transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

While the activities of Care Managers secure access to an individual's needed services, the activities of care coordination do not include:

1. The actual provision of the service;
2. Medicaid eligibility determinations/redetermination;
3. Medicaid pre-admission screening;
4. Prior authorization for Medicaid services;
5. Required Medicaid utilization review;
6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) administration;
7. Activities in connection with "lock-in" provisions under §1915(a) of the Social Security Act;
8. Institutional discharge planning as required of hospitals, Skilled Nursing Facilities (SNFs), and ICFs/IIDs; and
9. Client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

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Effective July 1, 2018 the following fees will be in effect for the Targeted Case Management Service. The Basic HCBS Plan Support-initial fee is a one-time payment made in the first month of service for the individual. One unit of Basic HCBS Plan Support-on-going may be billed per quarter (up to four units per year). A provider may not bill both an initial and an on-going fee in the same quarter. In order to be reimbursed for a billable unit, the CCO/HH provider must, at a minimum, provide at least one of the monitoring, or follow-up activities, or conduct a face to face visit.

Rate Code	Rate Code Definition	Locator Code	Fee
1904	Basic HCBS Plan Support- on going	03/04	$247.25
1906	Basic HCBS Plan Support- initial	03/04	$741.74

New York
10-2

RESERVED

[TYPE OF SERVICE

Case Management Services
Target Group B:

Persons enrolled in Medical Assistance who:

(1) Have a documented diagnosis of mental retardation or a developmental disability as defined in New York Mental Hygiene Law § 1.03, and

(2) Are in need of ongoing comprehensive service coordination rather than incidental service coordination, and

(3) Have chosen to receive the services, and

(4) Do not reside in intermediate care facilities for the developmentally disabled; State operated developmental centers; small residential unit (SRU); nursing facilities, or hospitals or any other medical assistance institutional settings that provide service coordination, and

(5) Are not concurrently enrolled in any other comprehensive service coordination service funded under Medical Assistance.

METHOD OF REIMBURSEMENT

The method of reimbursement shall be a monthly fee established by OMRDD in conjunction with the New York State Department of Health and approved by the New York State Division of the Budget.

The method of reimbursement described in the paragraph above will sunset effective March 31, 2013.]

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Page 3(h.13)

[Effective April 1, 2013, the methodology described in the Rate Setting and Financial Reporting for Medicaid Service Coordination (MSC) services provided by OPWDD and voluntary agency providers.

Definitions (applicable to this section)

Regular-Basic – MSC service provided for an individual residing in a certified OPWDD setting, i.e. Supervised or Supportive IRA or a Supervised or Supportive Community Residence.

Transition-Basic – MSC service provided for an individual that is new to the MSC service or transitioning from a certified OPWDD setting into the community. Transition payments are available when the individual with developmental disabilities is new to service coordination, that is, the person has never received any type of service coordination/case management service through OPWDD's system, i.e., MSC, CMCM, PCSS, HCBS Waiver, state paid service coordination, Care at Home, etc. Transition payments are also available when the person moves from an OPWDD certified supervised or supportive IRA or supervised or supportive Community Residence to his or her own home or apartment and is responsible for his or her own expenses. It is a onetime payment made in the first month of services, or when a qualifying move occurs.

Regular-Willowbrook – MSC service provided for an individual who is designated as a member of the Willowbrook Class as defined by The Willowbrook Permanent Injunction and who resides in a certified OPWDD setting, i.e. Supervised or Supportive IRA or a Supervised or Supportive Community Residence.

Transition-Willowbrook – MSC service provided for an individual who is designated as a member of the Willowbrook Class as defined by The Willowbrook Permanent Injunction and who is transitioning from a certified OPWDD setting into the community. Transition payments are available when the individual with developmental disabilities is new to service coordination, that is, the person has never received any type of service coordination/case management service through OPWDD's system, i.e., MSC, CMCM, PCSS, HCBS Waiver, state paid service coordination, Care at Home, etc. Transition payments are also available when the person moves from an OPWDD certified supervised or supportive IRA or supervised or supportive Community Residence to his or her own home or apartment and is responsible for his or her own expenses. It is a onetime payment made in the first month of services, or when a qualifying move occurs.

1. For voluntary agency providers, the method of reimbursement will be a monthly fee established by OPWDD in conjunction with the New York State Department of Health and approved by the New York State Division of the Budget. The fee schedule to be paid to contracted voluntary providers is as follows:

Rate Code	Rate Code Definition	Locator Code	Fee
5211	Regular-Basic	03	$252.98
5211	TransitionBasic	04	$758.94
5214	Regular-Willowbrook	03	$474.34
5214	Transition-Willowbrook	04	$1,423.02

]

[The reporting requirements for voluntary providers are the same as those described in paragraph (n) of Attachment 4.19-D - Part II.

i. Effective April 1, 2015, the MSC fees will reflect 2% COLA increases as follows:

Rate Code	Rate Code Definition	Locator Code	Fee
5211	Regular-Basic	03	$256.52
5211	Transition Basic	04	$769.55
5214	Regular-Willowbrook	03	$480.97
5214	Transition-Willowbrook	04	$1,442.92

Effective April 1, 2013 through December 31, 2014, for state-provided services, the method of reimbursement will be a monthly fee established by OPWDD in conjunction with the New York State Department of Health and approved by the New York State Division of the Budget. The fee schedule to be paid to State Operated providers as follows:

Rate Code	Rate Code Definition	Locator Code	Fee
5210	Medicaid Service Coordination State - Regular	03	$438.23
5210	Medicaid Service Coordination - Transition	04	$1,314.69

2. To reconcile Medicaid Service Coordination the following method will be followed:
   I. Medicaid Service Coordination –
      (a) Total Operating Costs from CFR1 Line 64;
      (b) Less/ Plus Adjustments from CFR1 Line 66;
      (c) The result of (a) and (b) results in the Total Operating Adjusted;
      (d) The sum of (c) and CFR1 Property and Equipment, Lines 48 and 63, is divided by the Units of Service as reported on CFR1 Line 13.]