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State/Territory Name: New York

State Plan Amendment (SPA) #: 13-0035

This file contains the following documents in the order listed:

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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

October 23, 2015

Jason A. Helgeson
State Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs
New York State Department of Health
Corning Tower (OCP-1211)
Albany, New York 12237

Dear Mr. Helgeson:

We are pleased to enclose a copy of approved New York State Plan Amendment (SPA) 13-0035, submitted to my office on December 30, 2013. Pursuant to section 1915(k) of the Social Security Act, this SPA establishes a new 1915(k) attachment to the State Plan in order to implement a Community First Choice (CFC) State Plan Option to provide home and community based attendant services and support. This SPA amends section 4.19B of the State Plan to set forth the reimbursement methodology of CFC.

This SPA has been approved effective July 1, 2015, as requested by the State.

Changes are reflected in the following sections of your approved State Plan:

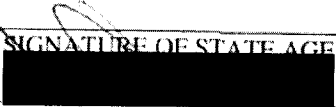

- Attachment 3.1K Supplement, Page 1 - 23
- Attachment 4.19B, Page 6(a)(v) - 6(a)(ix)

If you have any questions regarding this matter you may contact Maria Varon (212) 6160-2503 or by email at Maria.Varon@cms.hhs.gov.

Sincerely,

/s/

Michael A. Melendez
Associate Regional Administrator

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 13-0035	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		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 July 1, 2015	
5. TYPE OF PLAN MATERIAL (Check One): <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 (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: § 1902 of the Social Security Act; 42 CFR 441 Subpart K & 1915(k) of the Social Security Act		7. FEDERAL BUDGET IMPACT: (in thousands)* a. FFY 07/01/15-09/30/15 \$ 10,662.04 b. FFY 10/01/15-09/30/16 \$ 36,000.00	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: 6(a)(v), 6(a)(vi), 6(a)(vii), 6(a)(viii), 6(a)(ix) Attachment 3.1-K Supplement: Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	
10. SUBJECT OF AMENDMENT Community First Choice Option *Note: the impact in box 7 is based only on the extra 6% FMAP attributable to CFCO expenditures.			
11. GOVERNOR'S REVIEW (Check One): <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 and Rate Setting 99 Washington Ave - One Commerce Plaza Suite 1460 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgeson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: DEC 30 2013			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: OCTOBER 23, 2015	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: JULY 01, 2015		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: MICHAEL A. MELENDEZ		22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIVISION OF MEDICAID & CHILDREN'S HEALTH	
23. REMARKS:			

State Plan under Title XIX of the Social Security Act
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Community First Choice Option

On December 18, 2013, New York State convened a meeting of its appointed Development and Implementation Council, comprised of a majority of individuals who are aged and/or physically, mentally/behaviorally, or developmentally/intellectually disabled or their representatives, as required by federal statute. The Council reviewed and unanimously approved the below proposed State Plan Amendment to implement the Community First Choice Option in New York State.

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by Centers for Medicare and Medicaid Services (CMS) through interpretive issuance or final regulation.

i. Eligibility

Community First Choice Option (CFCO) services are available to (New York) State Plan eligible groups as described in Section 2.2-A of the State Plan. These individuals are eligible for medical assistance under the State plan and are in an eligibility group that includes nursing facility services, or, if an eligibility group under the State plan that does not include such nursing facility services, have an income that is at or below 150 percent of the Federal poverty level (FPL). In determining whether 150% of the FPL requirement is met, States must apply the same methodologies as would apply under their Medicaid State plan, including the same income disregards in accordance with section 1902(r)(2) of the Act.

Individuals who are receiving medical assistance under the special Home and Community-Based (HCB) waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must continue to meet all 1915(c) requirements and must receive at least one HCB waived service per month. Individuals receiving services through CFCO will not be precluded from receiving other HCB Long Term Care (LTC) services and supports through other Medicaid State Plan, waiver, grant or demonstration, as appropriate, but will not be allowed to receive duplicative services in CFCO or any other available community-based services.

During the five year period that begins January 1, 2014, spousal improvement rules are used to determine the eligibility of individuals with a community spouse who seek eligibility for home and community based services provided under 1915(k), as directed by the guidance in the CMS State Medicaid Directors' letter#15-001, ACA #32, dated May 7, 2015.

For individuals eligible under section 1902(a)(10)(A)(ii)(VI) of the Act who continue to meet all of the 1915(c) waiver requirements and who are receiving the minimum frequency services needed – at least monthly or require monthly monitoring when services are furnished on less than a monthly basis, excess income determined under 42 C.F.R. 435.726 is applied, in addition to the

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cost of 1915(c) waiver services, to the cost of 1915(k) services. Therefore, excess income is applied to both 1915(c) waiver and 1915(k) services.

The State will ensure that a determination is made initially, and at least annually, that individuals require the Level of Care (LOC) provided in a hospital, a nursing facility, an intermediate care facility for Individuals with Intellectual Disabilities (ICF/IID), an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over. LOC for individuals between ages 21 and 65 needing psychiatric services is determined using hospital, ICF or nursing facility LOC criteria. Various functional assessment tools in use across disability populations in New York State (NYS) will include a LOC outcome either as part of the assessment or separately and will also be used to inform a person-centered plan of care. Different tools are utilized in order to accurately assess an individual's specific needs based on the relevant institutional LOC being assessed (i.e. a skilled nursing facility, hospital, intermediate care facility, institute for mental disease, etc.).

A person-centered plan of care, also known as the Service Plan (SP) will be developed for CFCO-eligible individuals based on a comprehensive functional assessment that, in part, identifies the individual's needs and goals related to living independently in the community. The agent of state government (i.e. local district for social services, regional developmental disability office or service coordinator or their delegate, etc.) or managed care entity must review the individual's service needs at least annually, upon a significant change in the individual's condition or if requested by the individual. The date of review and signature is required on the SP. The update to the SP will occur no less than annually and as informed by the assessment. Also, annually a review is conducted to assure that the individual continues to meet the LOC criteria.

ii. Service Delivery Models

Service delivery model options under CFCO are described below. New York State will offer both an Agency Model and an Agency with Choice model. These are described in detail below.

X Agency Model – The Agency Model is based on the person-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by personal care aides, personal attendants, home health aides, or direct service professionals (collectively referred to as direct care workers throughout the SPA pages) employed by a traditional agency or provider. CFCO participants will still exercise as much control over the selection, management and, if necessary, dismissal of their direct care worker as they desire. The Local Department of

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Social Services, a managed care entity, or a non-profit organization, which includes not-for-profit corporations formed under New York State Law or authorized to do business in New York, may contract with home care agencies or providers to deliver CFCO services.

X Agency with Choice Model – this model is also based on the person-centered assessment of need and will be used when the individual seeking CFCO services wants to directly hire his or her own attendant. This attendant may be a relative other than a parent or a spouse, a neighbor, a friend or an independent attendant. In this delivery model, the individual will select, manage, train and, if necessary, dismiss his or her own attendant. A fiscal intermediary will be used to keep track of the attendant's hours, pay the attendant and deduct required amounts for taxes and insurance from the attendant's check. Fiscal intermediaries can be licensed home care services agencies, independent living centers, or other entities that pay attendants/direct care workers who are employed directly by the recipient of CFCO LTSS. CFCO participants must have a free choice of fiscal intermediaries.

There is no budget authority under either of these models.

Self-Directed Model with service budget – This Model is one in which the individual has both a SP and service budget based on the person-centered assessment of need.

___ Direct Cash

___ Vouchers

___ Financial Management Services in accordance with 441.545(b)(1)

___ Other Service Delivery Model as described below:

iii. Service Package

A. The following are included CFCO services (including service limitations):

Services may be provided in the individual's home and in the community by direct care workers.

1. Assistance with ADLs, IADLs and health-related tasks through hands-on assistance, supervision, and/or cueing.

The State will cover personal care services and supports related to core ADLs including: assistance with bathing/personal hygiene/grooming, dressing, eating, mobility (ambulation, transferring and positioning), and toileting.

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In addition, personal care services and supports will be available related to core IADLs including: managing finances; providing or assisting with transportation (in conjunction with approved service noted in service plan); shopping for food, clothes and other essentials; meal preparation; using the telephone and/or other communication devices; medication management; light housekeeping; and laundry.

Health-related tasks are specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by a direct care worker. These tasks include, but are not limited to: performing simple measurements and tests; assisting with the preparation of complex modified diets; assisting with a prescribed exercise program; pouring, administering and recording the administration of medications; assisting with the use of prescribed medical equipment, supplies and devices; assisting with special skin care; assisting with a dressing change; and assisting with Ostomy Care.

CFCO participants will have continued access to other health-related services and long term services and supports through the State plan, waivers or demonstrations, for which the enhanced FMAP available under CFCO will not accrue.

Providers: Personal Care Aides, Personal Attendants, Personal Assistants, Home Health Aides, and Direct Service Professionals that meet the licensure and certification requirements under NYCCR Title 18 and the guidance of the Department of Health and/or the Office for People With Developmental Disabilities and the Office of Mental Health are qualified providers of personal care services and supports under CFCO.

2. Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs and health-related tasks.

The State will cover services and supports related to assistance with functional skills training through hands-on assistance, supervision and/or cueing to accomplish the ADL, IADL and health-related tasks. Services will be specifically tied to the functional needs assessment and person-centered SP and are a means to maximize independence and integration in the community, preserve functioning and defer or eliminate the likelihood of future institutional placement.

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These services may include: assessment, training, and supervision of, or assistance to, an individual with issues related to self-care, life safety, medication management, communication skills, mobility, community transportation skills, community integration, reduction/elimination of maladaptive behaviors including inappropriate social behaviors, problem solving skills, money management, and skills to maintain a household, as it relates to the provision of ADLs, IADLs, and health related tasks.

A direct care worker whose qualifications are approved by the Department of Health (DOH), the Office for People With Developmental Disabilities (OPWDD) or the Office of Mental Health (OMH) may provide training and maintenance activities under the following conditions:

- The need for skill training or maintenance activities has been determined through the assessment process and has been authorized as part of the person-centered SP;
- The activities are for the sole benefit of the individual and are only provided to the individual receiving CFCO services;
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the person has a progressive medical condition;
- The activities provided are consistent with the stated preferences and outcomes in the person-centered SP;
- The activities provided are concurrent with the performance of ADLs, IADLs and health-related tasks as described in the earlier section;
- Training and skill maintenance activities that involve the management of behavior during the training of skills must use positive reinforcement techniques; and
- The provider is authorized to perform these services for CFCO recipients and has met any required training, certification and/or licensure requirements.

Providers: Personal Care Aides, Personal Attendants, Personal Assistants, Home Health Aides, and Direct Service Professionals that meet the licensure and certification requirements under NYCCR Title 18 and the guidance of the Department of Health and/or the Office

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for People With Developmental Disabilities and the Office of Mental Health are qualified providers of functional skills training under CFCO.

3. Back-up systems or mechanisms to ensure continuity of services and supports.

The State will cover back-up systems and mechanisms to ensure the continuity of services and supports and the safety and well-being of the individual. These systems and mechanisms include:

• **Electronic back-up systems:**

- Personal Emergency Response Systems (PERS) provide back-up for individuals who live alone or are alone for significant periods of time in their own homes.
- Electronic devices to secure help in an emergency for safety in the community and other reminders that will help an individual with activities such as medication management, eating or other monitoring activities.
- Examples of electronic devices include PERS, medication reminders, medical monitoring devices, and alert systems for meal preparation, ADL and IADL supports that increase an individual's independence.
- Mobile electronic devices and other assistive technology will be reviewed on a case-by-case basis to determine the potential to replace human interventions as identified in the person-centered SP.

Relief Care: Service Coordinators (SC) will assist with identifying regularly-scheduled direct care workers as part of the Service Plan (SP). Identified back-up direct care workers or care setting alternatives (such as the home of a relative or other private home) are part of the plan of care.

Providers: Personal Care Aides, Personal Attendants, Personal Assistants, Home Health Aides, and Direct Service Professionals that meet the licensure and certification requirements under NYCCR Title 18 and the guidance of the Department of Health and/or the Office for People With Developmental Disabilities and the Office of Mental Health are qualified providers of relief care services and supports under CFCO.

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4. Voluntary training on how to select, manage and dismiss attendants:

The State will make a training program to assist individuals in selecting, managing and dismissing personal care attendants available to CFCO participants. During the initial functional needs assessment, training programs will be identified and made available to individuals. In addition, on an annual basis, training programs will again be identified and made available to individuals. Training formats range from in-person to web-based and will be made specific to CFCO. All formats suggested will be deemed appropriate and accessible to individuals.

iv. Support System Activities

The following steps will be taken to support an individual in both a fee-for-service model and a managed care model. Fee-for-service: services provided by a local district or a regional office of OPWDD or its delegates. Managed Care (MC) or Managed Long Term Care (MLTC) plans conduct these activities on their own. The State ensures that these activities take place through its model contracts, MOUs, Administrative Agreements, and quality assurance efforts.

Support activities will include the following:

- a) Functional needs assessment and counseling prior to enrollment in CFCO;
- b) Information, counseling, training and assistance to ensure that an individual is able to manage the services;
- c) Information communicated to the individual in a manner and language understandable by the individual, including needed auxiliary aids and/or translation services;
- d) Conducting person-centered planning;
- e) Range and scope of available choices and options;
- f) Process for changing the person-centered SP;
- g) Grievance process;
- h) Risks and responsibilities of self-direction;
- i) Free Choice of Providers;
- j) Individual rights and appeal rights;

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- 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.

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.

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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. 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 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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Safeguards are significant issues discovered during the planning process that are individualized and specific to the participant. The SP includes a description of the supervision and oversight that may be required in such areas as fire safety, medication management, allergies, community inclusion activities, diet, behavioral concerns, financial transactions, natural disaster preparation, bathing safety and vulnerabilities at home and in the community. Providers monitor and document safeguards as services are provided and through routine checks by direct care workers and their supervisors in accordance with the schedule established by the local district or the (managed or managed long term care) plan. In addition, they must report incidents to state authorities.

Providers: The risk assessment is conducted by the nurse or social worker conducting the functional assessment and/or the individual developing the person-centered service plan.

v. The State elects to include the following CFCO permissible service(s):

- ✓ 1. Expenditures relating to a need identified in an individual's person-centered plan of services that increases an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for human assistance. These include:

Environmental Modifications: Modifications are provided in accordance with 441.520(b)(2).

Assistive Devices: Any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living. Examples of assistive technology include, but are not limited to: motion and sound sensors, two way communication systems, automatic faucet and soap dispensers, toilet flush sensors, incontinent sensors and fall sensors.

Congregate and/or home delivered meal services: up to two meals per day for individuals who cannot prepare or access nutritionally adequate meals for themselves and the cost of this service is less than it would be to have someone provide in-home meal preparation.

- ✓ 2. Expenditures for transition costs in accordance with 441.520(b)(1) such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for individuals with developmental/intellectual disabilities, or a provider controlled residence certified by OPWDD to a community-based non-certified home setting where the individual resides. These expenditures are limited to individuals transitioning from a nursing facility, IMD, or an ICF/IID to a home or community-based setting where the individual resides.

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Providers: Environmental modifications and Vehicle modifications must be completed by individuals who are qualified and/or licensed to comply with State and local rules; all materials and products used must meet any State and local construction requirements and providers must adhere to any State and local safety standards pursuant to Article 18 of the New York State Uniform Fire Prevention and Build Code Act as well as local building codes.

Assistive Technology (AT) services are purchased through vendors who sell the needed medical, communication and adaptive equipment or supplies.

Providers of AT must be:

1. Approved by DOH under Section 504 of Title 18 NYCRR;
2. Providers of AT services approved by OPWDD;
3. A licensed pharmacy; or
4. For Personal Emergency Response Systems (PERS), an approved provider of PERS which have existing contracts with the LDSS or managed care organization.

Providers of AT must ensure that all devices and supplies meet standards established by Underwriters Laboratory and/or comply with FCC Regulations, if appropriate. The provider is responsible for training the CFCO participant, natural and paid supports who will be assisting the participant in using the equipment and/or supplies.

Congregate and Home Delivered Meal providers include Meals on Wheels and other meal delivery services contracted by local area agencies on aging or arranged by managed care organizations or local departments of social services. Any facility or agency used to provide this service must comply with 10 NYCRR Part 14 for Food Service Establishments.

Moving services are provided by moving companies appropriately licensed/certified by the New York State Department of Transportation.

vi. Service Limits

Service levels for community based services and allowable activities for in-home services are based on the individualized functional assessment of service needs and are to be provided without other limitation on their scope, duration or cost. See 18 NYCRR 505.14(a)(6)(i)(b).¹

¹ Except where individuals require only services and supports to address environmental and nutritional supports (light housekeeping tasks; shopping and/or meal preparation). These services and supports will be limited to 8 hours per week. Any changes in an individual's condition or service needs will result in a reassessment to determine the need for additional services.

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Transition services will be limited to necessary services for individuals transitioning from an institution into a community-based or in-home program. Services will be based on an assessed need, determined during the person-centered service planning process and will support the desires and goals of the individual receiving services and supports. Costs will be limited to a one-time expense of up to \$5,000 and service coordinators will fill out and maintain forms detailing the projected and final expenses and what items and/or services were purchased.

Transition services will be limited to: moving and move-in costs including; movers, cleaning and security deposits, payment for background/credit check (related to housing), initial deposits for apartments, heating, lighting and phone; and payment of previous utility bills that may prevent the individual from receiving utility services and basic household furnishing (i.e. bed) and other items necessary to re-establish a home.

Contracts for environmental modifications may not exceed \$15,000 without prior approval of DOH.

Contracts for vehicle modifications are limited to the primary vehicle of the recipient and may not exceed \$15,000 without prior approval of DOH.

Assistive Technology costs cannot exceed \$15,000 per year. Items that cost up to \$1,000 a year only require one bid; those over \$1,000 a year require three bids. Coverage will be limited to assistive technology devices that are not available through the State Plan Durable Medical Equipment included in the eMedNY Manual at <https://www.emedny.org/ProviderManuals/DME/index.aspx>, and cannot duplicate a device purchased through a 1915(c) waiver.

In all cases, service limits are soft limits that may be exceeded due to medical necessity.

Individuals will work with their service planners and/or care managers to determine whether or not their needs can be met within the limits established under the Community First Choice Option as they are completing the person-centered service plan. If the individual's needs cannot be met within these limits, the individual may appeal to the Department of Health for consideration of the additional costs.

Distinct service elements, procedure codes and claim modifiers will differentiate whether the services are State plan services or other Medicaid Services under 1915(c) or other authorities. This will control and mitigate duplication of services.

vii. Use of Direct Cash Payments

- a) The State elects to disburse cash prospectively to CFCO participants. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.
- b) The State elects not to disburse cash prospectively to CFCO participants.

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viii. **Assurances**

- A. The State assures that any individual meeting the eligibility criteria for CFCO will receive CFCO services.
- B. The State assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for CFCO services including adherence to section 1903(i) of the Act that Medicaid payment shall not be made for items or services furnished by individuals or entities excluded from participating in the Medicaid program.
- C. The State assures the provision of eligible individual controlled HCB attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of HCB attendant services and supports that the individual requires in order to lead an independent life.
- D. With respect to expenditures during the first full 12 months in which the State plan amendment is implemented, the State will maintain or exceed the level of State expenditures for HCB attendant services and supports provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding 12 month period.
- E. The State assures the establishment and maintenance of a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports that includes:
 - i. A quality improvement strategy;
 - ii. Methods to continuously monitor the health and welfare of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports.
- F. The State assures the collection and reporting of information, including data regarding how the State provides HCB attendant services and supports and other HCBS, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under CFCO the choice to instead receive HCBS in lieu of institutional care.

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- G. The State will provide the Secretary with the following information regarding the provision of HCB attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:
- i. The number of individuals who are estimated to receive HCB attendant services and supports under this option during the federal fiscal year.
 - ii. The number of individuals that received such services and supports during the preceding federal fiscal year.
 - iii. The specific number of individuals served by type of disability, age, gender, education level, and employment status.
 - iv. The specific number of individuals previously served under any other home and community based services program under the State plan or under a CFCO.
 - v. Data regarding the impact of Community First Choice services and supports on the physical and emotional health of individuals.
 - vi. Other data as determined by the Secretary.
- H. The State assures that HCB attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws consistent with 441.570(d)(1)-(5).
- I. The State assures it established a Development and Implementation Council prior to submitting a State Plan Amendment in accordance with section 1915(k)(3)(A). The council is primarily comprised of eligible individuals who are individuals with disabilities, elderly individuals and their representatives. The membership and meeting dates are available at this link: [http://www.health.ny.gov/facilities/long term care/#cfco](http://www.health.ny.gov/facilities/long_term_care/#cfco).
- J. The State assures that individuals receiving services through Community First Choice will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State Plan, waiver, grant or demonstration authorities.
- K. The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification, a separate Community First Choice section which outlines the following:
- i. Any program changes based on the inclusion of Community First Choice services in the health plan benefits
 - ii. Estimates of, or actual (base) costs to provide Community First Choice services (including detailed a description of the data used for the cost estimates)
 - iii. Assumptions on the expected utilization of Community First Choice services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
 - iv. Any risk adjustments made by plan that may be different than overall risk adjustments
 - v. How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM.

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- L. Transportation services will only be available to a location that is identified in the person-centered service plan pursuant to a functional need identified in the person's assessment. Specifically, New York makes the following assurances:
- i. The functional needs assessment and the person-centered service plan indicate the need for a medical escort, the need for transportation to medical appointments and traveling around and participating in the community;
 - ii. There is a checks and balances system in place to monitor services to ensure that duplicate billing doesn't take place; and
 - iii. CFCO SPAs that allow personal care attendants to provide transportation to medical appointments should follow the guidelines that Non-Emergency Medical Transportation (NEMT) uses to ensure the integrity of the transportation services.

ix. Assessment and the SP

Assessment Process

Eligibility for New York State's Medicaid-supported home and community based long term services and supports is determined by a number of federally-approved assessments. The State will not seek additional FMAP for this administrative function.

These assessment tools will assess individuals across dozens of critical domains such as: function, cognition, behavior, communication, informal supports, clinical, etc. While the UAS-NY determines LOC, not all functional needs assessments in use do, so it will be determined separately. All functional needs assessments will record the individual's needs, strengths, preferences and goals for maximizing their independence and community integration through questions geared to elicit this information, which is essential to the person-centered planning process. They will be completed face-to-face with each individual by assessor(s) who are specifically trained in the use of the functional needs assessment. The service recipient will be able to request the participation of any one he or she wants involved in the functional needs assessment and service planning process.

Registered nurses or a Qualified Intellectual Disabilities Professional (QIDP) will conduct the functional needs assessment prior to the person centered planning process in a face-to-face meeting with the individual in his or her home or chosen community or service setting, in an institutional setting from which he or she wishes to transfer to the community, or as part of his or her discharge from clinical or acute care. Depending on whether the individual is enrolled in a Care Management for All environment (managed care, managed long term care, health home, ACO, waiver, etc.) or is receiving or seeking fee-for-service assistance, the nurse or QIDP will be employed by a provider agency, the State, county or local government or designee, or the managed care entity.

Individuals will be reassessed at least annually, or as needed when the individual's support needs or

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circumstances change significantly necessitating revisions to the person-centered service plan, and at the request of the individual. Individuals will be informed that if they would like to be reassessed due to such changes, they need to notify their coordinator of the change and request a reassessment.

Development of the Person-Centered Service Plan (SP)

The results of the assessments will inform the development of a SP. The State will also not seek additional FMAP for this administrative function. The individual selects the people he or she wants to participate in the service planning process. A trained service coordinator will meet with each individual to assist them in identifying strengths and needs as well as identifying measurable goals and desired outcomes utilizing the results of the standardized assessment tool(s) and the person centered planning process. The SP will identify specific services and service providers used to meet stated goals; as well as their frequency, amount, and duration. During this process, natural supports will be identified and contingency plans will be developed. Natural Supports are defined as resources available to an individual from their relatives, friends, significant others, neighbors, roommates and the community. Natural supports are determined to be available when an individual is willing to voluntarily provide the identified services and the service recipient is willing to accept services from the natural support. If the natural support is unwilling or unable to provide the identified services, paid supports will be provided. Nothing in the natural support determination prevents DOH from paying qualified family members who are performing paid work. The State will not provide services or supports that are within the range of activities that a parent/legally responsible individual would ordinarily perform on behalf of a child without a disability or chronic illness of the same age.

If natural supports that were available and willingly provided become unavailable for any reason, this would be an event that would trigger a call to the service coordinator for immediate attention. The individual may require back-up supports or relief care and/or reassessment to ensure his or her continued safety and well-being as well as the maximization of independence and community integration. The individual and his or her natural supports will be made aware of the process to follow in the case of a change in the supports' availability during the person-centered planning process.

As noted in the previous section, a risk assessment plan will also be completed and considered a key component of the SP. Most importantly, the SP will be person-centered and understandable to the individual. Service Plans will be reviewed at least annually, and more often as indicated. The State will assure that the person-centered SP is completed in a manner that:

- i. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- ii. Is timely and occurs at times and locations of convenience to the individual;
- iii. Reflects cultural considerations of the individual;
- iv. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;

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- v. Offers choices to the individual regarding the services and supports they receive and from whom;
- vi. Includes a method for the individual to request updates to the plan; and
- vii. Records the alternative home and community-based settings that were considered by the individual.

Person-Centered SP Requirements: The person-centered SP will reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. The plan must:

1. Reflect that the setting in which the individual resides is chosen by the individual;
2. Reflect the individual's strengths and preferences;
3. Reflect clinical and support needs as identified through an assessment of functional need;
4. Include individually identified goals and desired outcomes;
5. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. (Natural supports cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual.);
6. Reflect risk factors and measures in place to minimize them, including individualized backup plans;
7. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her;
8. Identify the individual and/or entity responsible for monitoring the plan; and
9. Be finalized and agreed to in writing by the individual and signed by all individuals and the staff person responsible for writing the person-centered service plan.
10. Be distributed to the individual and other people involved in the plan.
11. Incorporate the service plan requirements for the self-directed model with service budget at § 441.550, when applicable.
12. Prevent the provision of unnecessary or inappropriate care.
13. Other requirements as determined by the Secretary.

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x. HCBS Settings

All CFCO services will be provided in a home or community-based setting, which does not include a nursing facility, hospital providing long-term care services, institution for mental disease, intermediate care facility for individuals with an intellectual disability or related condition, or setting with the characteristics of an institution. All services will be provided in settings that will comply with 42 CFR §441.530. The State has processes and procedures to ensure ongoing compliance with the setting requirements outlined in 42 CFR 441.530. Settings include the individual's own home or a family member's home that meets the settings criteria outlined in 42 CFR 441.530. Settings do not include provider-owned or controlled residential settings. The State will amend this SPA once it determines that other settings meet the settings criteria outlined in 42 CFR 441.530.

xi. Qualifications of Providers of CFCO Services

The State CFCO utilizes the agency-provider model for the provision of service delivery. As such, contracted entities must be approved by DOH, OPWDD or OMH. Approved agencies must meet and maintain standards for CFCO and all related state and federal regulations.

Personal Care Aides, also called personal care attendants, are certified by the State Education Department and must complete a minimum 40 hour training course with 6 hours of continuing education annually.

Home health aides are also certified by the State Education Department and must complete a minimum 75 hour training course with 12 hours of continuing education annually.

Aides in each of the above titles must meet the following minimum requirements in addition to the training requirements described above:

- (i) maturity, emotional and mental stability, and experience in personal care or homemaking;
- (ii) ability to read and write, understand and carry out directions and instructions, record messages, and keep simple records;
- (iii) sympathetic attitude toward providing services for individuals at home who have medical problems;
- (iv) good physical health, as indicated by the documentation in the personnel file of all persons providing personal care services;
- (v) a criminal history record check to the extent required by 10 NYCRR Part 402; and
- (vi) compliance with Part 403 of Title 10 NYCRR (Home Care Registry), as required in that Part.

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All of these aides provide personal care under the direction of a registered professional nurse or licensed practical nurse or therapist if the aide is to carry out simple procedures as an extension of physical, occupational, speech or language therapy. Supervising personnel visits are not eligible for the additional FMAP under CFCO.

Personal assistants are individuals that are directly hired by an individual in the agency with choice model. While they may be certified personal care or home health aides, they are not required to have these credentials. They must be adults that are not parent/guardians or spouses of the CFCO recipient. They are not required to undergo a criminal background check under state law unless they are certified aides.

Direct service professionals must be cleared through existing background check systems (ex. DOH, OPWDD and the Justice Center) where required by law and meet the additional qualifications listed below:

18 years or older and ability to:

- Follow both oral and written directions;
- Maintain simple records;
- Communicate effectively;
- Provide appropriate care;
- Safeguard personal information and maintain confidentiality; and
- Understand and follow emergency procedures.

Direct Service Professionals may work under the direction of supervising clinical personnel and these supervisory activities will not accrue the additional FMAP under CFCO.

Registered Nurses licensed by the State Education Department or Qualified Intellectual Disabilities Providers assessing individuals for services. The QIDP title is reserved for individuals with a bachelor's degree in a human services field and one year experience working with people with developmental or intellectual disabilities.

Medicaid Service Coordinators (who are involved in the person-centered planning process and development and monitoring of an individual's service plan) must complete training in the individual service plan, and in three of the following areas: home and community based waiver, introduction to person centered planning, self advocacy/self determination, quality assurance, and benefits and entitlements. They also must complete professional development hours annually.

New York State will also permit individuals to hire their own aide directly in addition to using agencies and/or the registry and in this case may waive the qualifications above to give the service recipient flexibility to hire a relative or someone in his or her personal network who can meet his or her needs without specific prior training.

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xii. Quality Assurance and Improvement Plans

The State's quality assurance and improvement plan is described below. It includes a quality improvement strategy, standards for agency-based models, feedback mechanisms for ensuring and maximizing consumer independence and consumer control, and risk management agreements established to monitor the health and well-being of each individual receiving CFCO supports and services.

A. Quality Improvement Strategy:

The primary measure of success of the quality assurance and improvement plan is whether the individual has been able to achieve his/her desired outcomes. Is the individual getting what he/she needs to live life as independently as possible and fully integrate into the community? The philosophy of CFCO, its policies and procedures have been developed to assure the greatest opportunity for individuals to be successful in the pursuit of their desired outcomes.

CFCO will adopt a Quality Management Program (QMP) that assures participant access, participant-centered service planning, provider capacity and capabilities, and participant safeguards, rights and responsibilities. CFCO will have a QMP designed to review operations on an ongoing basis, discover issues with operations, remediate those issues, and develop quality improvement initiatives to prevent the repeat of operational problems.

Entities involved in every aspect of CFCO will have responsibilities in implementing this QMP from the state in a policy development and oversight role, to providers, managed care and managed long term care plans and local representatives of the state (such as fiscal intermediaries, regional resource centers, and contracted agencies) in training service coordinators and other care managers and monitoring both service plans and participant satisfaction, to participants themselves, who retain the authority to dismiss attendants who fail to meet the standard established by the participant for his or her care as described in the service plan.

B. Standards for service delivery models for:

i. Training. Local representatives of the state office/agency and contracted entities are responsible for person-centered planning and other critical care management activities. Among these activities are monitoring the progress of each participant to ensure that the services provided are appropriate and in accord with the person-centered service plan and that the service plan continues to meet the participants needs.

ii. Denials and Reconsiderations. The State has standardized processes for informing individuals/representatives of their rights, recording hearing requests, completing pre-hearing summaries, conducting hearings, and notifying individuals/representatives of fair hearing outcomes. Data reflecting these issues will be maintained.

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The State communicates additions or revisions to processes to local, state or contracted case management entities through formal electronic transmittals and/or written guidance.

Individual service recipients and applicants, and their representatives, are provided timely written notices of any planned change in services or benefits, including denial, closure or reduction. For denials, the time frame varies between 30 and 90 days depending on the oversight agency/office in the State. For closure or reduction of benefits or services the time frame is 10 calendar days prior to the effective date of the proposed action. The notice includes the reason for the decision, administrative rules that support the decision and the individual's/representative's right to due process through a fair hearing process.

iii. Appeals. The local district or contracted entity notifies the individual about the Fair Hearing process during the initial assessment/service planning. As part of the notification of Fair Hearings procedure, the Service coordinator informs the individual that continuation of services must be requested by the individual within the specified timeframes. Results of the hearing are provided to the individual.

Service coordinators fully inform individuals of all available choices and service options. Documentation requirements and automated systems support QA efforts.

C. Feedback Mechanisms to ensure and maximize consumer independence and consumer control

The service planning process of CFCO participants will assure that individuals receive information, and assistance if necessary, to make a determination regarding the level of control they wish to exercise over their long term services and supports, either directly or through a chosen representative. Regular meetings with service coordinators will assure that the goals established in the service plan, including the level of control over these services and supports, are realized. Surveys and/or questions posed during assessment and reassessment will capture the degree to which each participant is satisfied with their independence and control, and measures chosen will reflect both quality of care and recipient satisfaction.

In 2012, DOH convened the Commissioner's Advisory Group on the Community First Choice Option, the majority of which was comprised of individuals with disabilities, elderly individuals and their representatives. In December of 2013, this group was designated the official Development and Implementation Council to consult and collaborate with the state in implementing CFCO. The state consults and collaborates with the Council periodically to inform and elicit feedback regarding the services and supports provided to individuals receiving CFCO services.

D. The methods used to continuously monitor the health and welfare of CFCO individuals.

Local entities, OPWDD or contracted entities will regularly monitor Service Plans to ensure the health and welfare of individuals receiving CFCO services. Through the use of risk management agreements, a monitoring plan will be developed with the individual to review services and supports. Individuals

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receiving CFCO services will be informed of their right to request a review of their SP to ensure that their health and safety needs are being met through their self-directed SP.

In accordance with the NYS Protection of People with Special Needs Act, all entities associated with CFCO are required to report alleged or actual neglect, abuse, or exploitation in connection with the provision of such services and supports. Additionally, abuse investigation service is provided through the NYS Justice Center as a means of monitoring the health and welfare of all vulnerable populations in NYS, including CFCO service recipients.

In addition, participants in CFCO will have access to the federally mandated Home Health Hotline (1-800-628-5972), which can be called 24 hours per day, seven days per week. Alternatively, complaints may be mailed to the Department of Health or faxed. All complaints are investigated by the Department's regional office with jurisdiction over the area from which the call originated. The most serious complaints require Department investigators to conduct interviews, review clinical/patient care records and other provider documentation, and perform other activities during the onsite visit to the agency.

Finally, through self-direction, CFCO participants have the ability to seek alternative aides to assist with their ADLs, IADLs and health-related tasks that may be performed under state law. The power to control your own attendant services to the extent desired may best maximize the individual's ability to ensure that his or her needs are being met and goals advanced.

E. The methods for assuring that individuals are given a choice between institutional and community-based services

The State assures all individuals eligible for services under CFCO are informed of feasible alternatives for community-based services. Consistent with the Olmstead Report filed with Governor Andrew Cuomo in October of 2013, self-direction is a critical goal of assuring that individuals are served in the most integrated setting whenever possible and individuals who are determined to be able to self-direct their services directly or through a representative will be determined potential candidates for New York's CFC State Plan Option. When an individual is determined to require the LOC provided in an institution, the individual or his or her representative will be:

1. Informed of any feasible alternatives available under CFCO or other HCB Service, and
2. Given the choice of either institutional or HCB services. The choice of institutional or HCB services is documented on each eligible individual's SP. The service coordinator is responsible for completion of the appropriate Freedom of Choice documentation.

F. The individual outcome measures associated with the receipt of community-based attendant services and supports that the State will monitor and evaluate.

The State has decided to choose measures that represent both quality of care and recipient satisfaction.

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1. Consumer Satisfaction Survey

On an annual basis, a statistically significant number representing individuals in all level of care who receive CFCO services and supports will be surveyed. The survey will be a comprehensive tool employed to gain valuable information related to consumer satisfaction and quality of care. In addition, the survey will also include an assessment of the individual's opinion in progress towards goals identified by the individual in their person-centered service plan. The State has chosen to implement the Money Follows the Person (MFP) Quality of Life survey amended with several questions from the Participant Experience Survey (PES). The State may use the services of an independent contractor to perform these surveys with CFC participants to address staff needs and objectivity. Upon completion of each survey, percentages will be calculated and reviewed, and the results analyzed to determine if CFCO recipients are indeed satisfied with their home and community-based service and support needs. Are their support needs being met by the program? Are they able to satisfactorily self-direct their services? A report of survey findings will be disseminated to all CFCO participants, contracted service providers, county departments of social services, relevant state agencies and offices, and lastly, posted on the state's CFCO website.

2. UAS-NY utilization

The State has elected to use the Uniform Assessment System of New York (UAS-NY), a tool customized for the state's aged and physically disabled population based on the InterRAI Suite, to measure the individual outcomes associated with the receipt of community-based attendant services and supports. The UAS-NY provides the State with access to quality data reports that will allow us to monitor and track pertinent information such as the individual's needs, strengths, preferences and goals for maximizing their independence and community integration. We will also be able to generate reports to determine if these personal goals are being met related to living an independent life integrated to the fullest extent in the community. Because the UAS-NY assessment tool is equipped to track data across years and report based on aggregate data by jurisdiction or program, as well as tracking individual participant outcomes and changes throughout time, we will be able to monitor and track long term changes in the clinical/functional status and needs of CFCO participants.

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Community First Choice Option

Methods and Standards for Establishing Payment Rates

Prior to implementing the CFC program, the State had already been offering CFC like services under various approved state plan and waiver programs authorities. Under CFC, these services have now been consolidated into a single program. For the first year of the CFC program, the State will continue to pay the same fees or use the same methodologies in effect on June 30, 2015 under the former state program to purchase CFC services.

1. Assistance with ADLs, IADLs and health-related tasks through hands-on assistance, supervision, and/or cueing. The State will use the current fee or methodology identified in the following programs for the providers listed in Attachment 3.1-K Supplement (Personal Care Aides, Personal Attendants, Personal Assistants, Home Health Aides, and Direct Service Professionals that meet the licensure and certification requirements under NYCCR Title 18 and the guidance of the Department of Health and/or the Office for People with Developmental Disabilities and the Office of Mental Health are qualified providers of personal care services and supports under CFCO).

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<u>Rate Code</u>	<u>State Program</u>	<u>Current Rate</u>	<u>Methodology</u>
<u>2602, 2622,</u> <u>2623, 2593,</u> <u>2594, 2601,</u> <u>2595, 2596,</u> <u>2681, 2631,</u> <u>2671, 2815,</u> <u>2816, 3855,</u> <u>3856, 3145,</u> <u>9795, 9863</u>	<u>Personal Care</u>	<u>\$20.21/hr*</u>	<u>Provider specific fees are established based on provider reported costs two years prior to the rate year and are posted at:</u> <u>http://www.health.ny.gov/facilities/long_term_care/reimbursement/pcr/</u> <u>and</u> <u>http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2015-01-01_lthhc_rates.htm</u>
<u>2422, 2423,</u> <u>2402, 2401,</u> <u>4764, 4769,</u> <u>4770, 4771,</u> <u>4772, 4777</u>	<u>Fiscal Intermediaries</u>	<u>\$17.41/hr*</u>	<u>Provider specific fees are established based on provider reported costs two years prior to the rate year and are posted at:</u> <u>http://www.health.ny.gov/facilities/long_term_care/reimbursement/pcr/</u> <u>Or statewide fees based on the level of service provided as set forth in Appendix C of the OPWDD Comprehensive HCBS Waiver (NY 0238).</u>
<u>2611, 2695,</u> <u>2810, 2825,</u> <u>3850, 3865</u>	<u>Home Health Care (aide only)</u>	<u>\$23.18/hr*</u>	<u>Provider specific fees are established based on provider reported costs two years prior to the rate year and are posted at:</u> <u>http://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/rates/index.htm</u>
<u>9997, 9994,</u> <u>9991</u>	<u>Transportation</u>	<u>Varies depending on mode, region</u>	<u>Fee schedule available at:</u> <u>https://www.emedny.org/ProviderManuals/Transportation/index.aspx</u>

*Weighted average fee provided for informational purposes only. Actual payment rates will be the State established fee for each provider.

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2. Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs and health-related tasks. The State will use the current fee or methodology identified in the following programs for the providers listed in Attachment 3.1-K Supplement.

Rate Code	Service	Current Rate	Methodology
<u>4722, 4723, 4724, 4725, 4741, 4742, 4743, 4744, 4755, 4756, 4757, 4758, 4765, 4766, 4767, 4768, 4796, 4797, 4798, 4799</u>	<u>Community Habilitation</u>	<u>N/A</u>	<u>Regional Fee for Provider-Delivered Community Habilitation Region 1: \$ 38.51 (1-to-1); \$ 24.07 (Group) Region 2: \$ 39.91 (1-to-1); \$ 24.95 (Group) Region 3: \$ 39.00 (1-to-1); \$ 24.37 (Group)</u>

3. Back-up systems or mechanisms to ensure continuity of services and supports.

Rate Code	Service	Current Rate	Methodology
<u>2609, 2616, 2809, 2818, 3823, 3831, 3858, 9981</u>	<u>Personal Emergency Response (PERS)</u>	<u>\$23.11/month*</u>	<u>Provider specific fees are established based on provider specific costs reported two years prior to the rate year and are posted at: http://www.health.ny.gov/facilities/ long_term_care/reimbursement/hhc/2013-01- 01_lthhc_rates.htm</u>

*Weighted average fee provided for informational purposes only. Actual payment rates will be the State established fee for each provider.

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4. Permissible services/Substitute for human assistance

Rate Code	Service	Current Rate	Methodology
<u>3143, 4482, 4483, 4484, 4485, 9752</u>	<u>Assistive Technology</u>	<u>100% of claim determined reasonable by the state.</u>	<u>AT is purchased through vendors who sell the needed medical, communication and adaptive equipment or supplies using a standard bidding process following the rules established by the Office of the State Comptroller. Under the process, items costing up to \$1000 a year require only one bid, those over \$1000 will require multiple bids.</u> https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_06/assistive_technology.htm
<u>9750</u>	<u>Vehicle Adaptation</u>	<u>100% of billed cost determined reasonable by the state</u>	<u>NHTD current methodology, limit \$15,000; separate from e-Mods limit</u> https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/nhtd_program_manual_with_forms.pdf
<u>3144, 4786, 9758, 9867</u>	<u>Community Transitional Services (establishing a household in the community from an institutional setting)</u>	<u>100% of claim/approved cost</u>	<u>One-time payment not to exceed \$5,000. Specific amount will be based on State review and approval of cost projections.</u>
<u>N/A</u>	<u>Durable Medical Equipment</u>		<u>Fee schedule available at:</u> https://www.emedny.org/ProviderManuals/DME/index.aspx
<u>4476, 4477, 4478, 4479, 9992, 9995, 9998, 9762, 9874</u>	<u>Environmental Modifications</u>	<u>100% of claim determined reasonable by the State</u>	<u>Qualified contractors are selected through a standard bidding process following the rules established by the Office of the State Comptroller. This process is described at:</u> https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_06/e-mods.htm

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4. Permissible services / Substitute for human assistance (continued):

<u>Rate Code</u>	<u>Service</u>	<u>Current Rate</u>	<u>Methodology</u>
<u>2682, 2685, 2835, 3874, 9781</u>	<u>Home Delivered Meals</u>	<u>\$5.79/Meal*</u>	<u>Provider specific fees are established based on reported costs and are posted on State website at: http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lthhc_rates.htm</u>
<u>2638, 2830, 3872</u>	<u>Congregate Meals</u>	<u>\$5.07/Meal*</u>	<u>Provider specific fees are established based on reported costs and are posted on State website at: http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lthhc_rates.htm</u>
<u>2636, 2831, 3870, 9787</u>	<u>Moving Assistance (transport of personal belongings)</u>	<u>\$58.79/hr*</u>	<u>Provider specific fees are established based on reported costs and are posted on State website at: http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lthhc_rates.htm</u>

*Weighted average fee provided for informational purposes only. Actual payment rates will be the State established fee for each provider.

Payments made for State plan services under 1915(k) authority do not duplicate payments made for similar services under 1915(c), 1915(i), 1915(j), or 1115 authorities.

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