Table of Contents

State/Territory Name: **New York**

State Plan Amendment (SPA) #: **15-0060**

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179 like data)
3) Approved SPA Pages

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

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

October 23, 2015

Jason Helgerson
Medicaid Director, Deputy Commissioner
Office of Health Insurance Programs
NYS Department of Health
Corning Towers (OCP-1211)
Albany, New York 12237

Dear Mr. Helgerson:

We have completed our review of New York's State Plan amendment (SPA) 15-0060 received in office on September 24, 2015 and find it acceptable for incorporation into New York's Medicaid State Plan. This SPA proposes to reflect technical change updates to Community First Choice.

Please note the approval date of this SPA is October 23, 2015 with an effective date of July 1, 2015. Copies of the approved State Plan pages and the signed CMS-179 are enclosed.

Should you have any questions or concerns please contact Tara Porcher at (212) 616-2418.

Sincerely,

/s/

Michael Melendez
Associate Regional Administrator
Division of Medicaid & Children's Health

Enclosures

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **New York**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

NY-15-0060

Proposed Effective Date

07/01/2015 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Section 1902(a)(10)(A)(i)(VIII) of the Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2013	$0.00
Second Year	2014	$0.00

Subject of Amendment

(ABP1) ABP Populations;
(ABP2a) Voluntary Benefit Pkg Selection Assurance-Elig Group; (ABP3) Selection of Benchmark Benefit Pkg or Benchmark-Equiv Benefit Pkg;
(ABP4) ABP Cost-Sharing;
(ABP5) Benefits Description;
(ABP7) Benefits Assurances;
(ABP8) Service Delivery Systems;
(ABP9) Employer Sponsored Ins & Pymt of Premiums;
(ABP10) General Assurances; and
(ABP11) Payment Methodology.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**
  Describe:
- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**
  Describe:
  These changes are technical and public notice and tribal notification are not required, per CMS. Therefore, this SPA did not go through the normal approval process via the Governor's office.

Signature of State Agency Official

Submitted By: **Michelle Levesque**

Last Revision Date: **Oct 27, 2015**

Submit Date: **Sep 24, 2015**

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-E- ☐ OMB Expiration date: 10/31/2014

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

- ☒ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☐ Prepaid Ambulatory Health Plans (PAHP).
- ☐ Primary Care Case Management (PCCM).

☒ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The state has provided Medicaid recipients enrollment in managed care plans since 1997. Medicaid Managed Care enrollment statewide is three million households. Another 400,000 adults are enrolled in managed care through an 1115 waiver program, Family Health Plus. Over 90 percent of Family Health Plus enrollees will be eligible for Medicaid under the new eligibility levels and are already enrolled in managed care. The state anticipates that only 77,000 enrollees will be newly eligible statewide in the adult group. As such, there was no need for an implementation plan for member or provider outreach. The state has engaged stakeholders in all aspects of ACA implementation, including the Medicaid expansion and the Alternative Benefit Plan.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ○ Section 1915(b) managed care waiver.
- ○ Section 1932(a) mandatory managed care state plan amendment.
- ◉ Section 1115 demonstration.

Alternative Benefit Plan

○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: April 1, 2013

Describe program below:

The Section 1115 demonstration Partnership Plan and the F-SHRP transfer of authority advanced the statewide managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

◉ Traditional state-managed fee-for-service

○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Traditional fee-for-service payment model. Providers are reimbursed at established rates for covered medically necessary services provided to enrollees prior to enrollment in managed care. Persons determined eligible for coverage have ten (10) days to select a health plan prior to auto assignment to a health plan. Enrollees may access state certified fee-for-service providers for medically necessary covered services not included in the managed care benefit package or not covered by the enrollee's health plan. These services include: non-emergency transportation services, nursing home services, hospice services, routine adult dental services and certain mental health and substance use disorder services. Managed care plans do not impose treatment limitations on MH/SUD services that are more restrictive than limitations defined in 3.1 A of the New York Medicaid state plan. MH and SUD benefits in the managed care benefit package are aligned with the state plan.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

All New York Medicaid Managed Care health plans provide members with a Member Handbook. The handbook explains the services covered by the health plan and the non-plan covered services that the enrollee must access via the fee for service delivery system. The New York Medicaid Managed Care Model Member Handbook is used by all participating health plans as an enrollee resource tool. Language in the handbook explains how to access both health plan covered services and services covered in the state plan that are not covered by the MMC plan contract; "Medicaid managed care provides a number of services you get in addition to those you get with regular Medicaid. [Insert Plan Name] will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP. These include emergency care; family planning/HIV testing and counseling; and specific self referral services, including those you can get from within the plan and some that you can choose to go to any Medicaid provider of the service."

There are medical services managed care enrollees must access via the FFS delivery system these include residential health care facility service, emergency/non-Emergency Transportation and hospice.
Certain mental health, substance use disorder and supportive services are not covered by health plans participating in the NYS Medicaid Managed Care program. Enrollees access these services via the FFS delivery system. This represents a full list to date, of behavioral health services not covered by the managed care benefit package: (recognizing some services listed serve children)
a)Chemical Dependence Services:
Outpatient Rehabilitation and Treatment Services Provided by OASAS Licensed Clinics:
Opioid Treatment Programs
Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs

Medically Supervised Ambulatory Chemical Dependence Outpatient Rehabilitation Programs
Outpatient Chemical Dependence for Youth Programs
Chemical Dependence Ordered by the LDSS

b) Mental Health Services:
Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)
Day Treatment
Continuing Day Treatment
Day Treatment Programs Serving Children
Home and School Based Services Waiver for Seriously Emotionally Disturbed Children
Case Management - target population SPMI
Partial Hospitalization
Services Provided Through OMH Designated Clinics for Children With A Diagnosis of Serious Emotional Disturbance (SED)
Assertive Community Treatment - ACT
Personalized Recovery Orientated Services- PROS

c) Rehabilitation Services Provided to Residents of OMH Licensed Community Residences and Family Based Treatment Programs

d) OPWDD Services (Office of Persons with Developmental Disabilities)
Long Term Article 16 Clinic Services
Day Treatment
Medicaid Service Coordination - MSC
Home and Community Based Services Waiver (HCBS)
Care at Home Program

e) Community First Choice Option (CFCO) services will be accessible to enrollees in both the managed care and the Fee For Service delivery systems. The Managed Care/Managed Long Term Care benefit plan currently available to enrollees in the managed care delivery systems include the following CFCO services:
personal care
home health care (provided by an aide)
consumer directed personal assistance program
transportation (must relate directly to a functional need specified in the person-centered service plan)
PERS
durable medical equipment (must relate directly to a functional need specified in the person-centered service plan)

The following CFCO services will be accessible via the FFS delivery system until the state plan amendment is approved. At that time, the services listed below will be included in the managed care/managed long term care benefit. Although, the services may not retain the same title when included, (for example, home and community support services is covered under waivers currently but will be incorporated into personal care under CFCO to include supervision and cueing).
community habilitation (services must be delivered in a non-certified setting)
home and community support services (supervision and cueing related to personal care)
home delivered and congregate meals (where substituted for paid attendant care; *home delivered meals are covered under MLTC but not MC)
assistive technology (as specified in the person-centered service plan; must increase independence or substitute for human assistance)
environmental modifications (must relate directly to a functional need specified in the person-centered service plan; $15,000/ year limit)
vehicle adaptation (must relate directly to a functional need specified in the person-centered service plan)
moving assistance (limited to a one-time expenditure of $5,000)
community transitional services (must be transitioning from institutional care to home and community based setting; limited to a one-time expenditure of $5,000)
fiscal intermediaries

f) Other Non-Covered Services:
The Early Intervention Program
Preschool Supportive Health Services
School Supportive Health Services
School Based Health Centers

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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