IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

VIOLETTE JEANNOT, YVONNE FRANCOIS, ANTONINA FRIMER, EUGENE KARASYUNOK, NELLI KOTSYUBA, PEDRO PERALTA, VITALIY ROZENBOYM, MARGARITA ROZENBOYM, CESAR RIOFRIO, MUHAMMAD O. ISLAM, TRINA-ROSE CUTUGNO, CAROL GITTENS, ELIZABETH DUNROD, ZILLA CUMMINGS, CHARLOTTE DEWITT, RASHIDA SMITH, AASHA SERVICES, INC., BANGLA CDPAP SERVICES INC., BEST HELP HOME CARE CORP., CAREAIDE DIRECT, INC., CAREFIRST CDPAP, CORP., CELESTIAL CARE INC., EASY CHOICE AGENCY, INC., ELIM HOME CARE AGENCY LLC, ENRICHED HOME CARE AGENCY INC., HEALTHY LIFE CHOICE, INC., HOME CHOICE LLC, THE DORAL INVESTORS GROUP, LLC, DBA HOUSE CALLS HOMECARE, INTERNATIONAL HOME CARE SERVICES OF NY, LLC, JUST CARE LLC, SAFE HAVEN HOME CARE, INC., SAFETY 1ST HOMECARE, INC., SILVER LINING HOMECARE AGENCY, INC., SUNDANCE HOME CARE INC., ALLCARE HOMECARE AGENCY, INC. DBA VIVID CARE Plaintiffs, v. NEW YORK STATE, NEW YORK STATE DEPARTMENT OF HEALTH, KATHY HOCHUL, in her official capacity as Governor of New York State, and JAMES V. MCDONALD, in his official capacity as Commissioner, New York State Department of Health Defendants.	)	Civil Action No.: 1:24-cv-05896

MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

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INTRODUCTION

The Defendants in this action seek to eliminate hundreds of small businesses in New York State, including the Plaintiff Agencies, and to upend the home health care services received by approximately ***246,000*** Medicaid beneficiaries, including the Plaintiff Consumers, all while blatantly ignoring their statutory and regulatory obligations to seek and obtain approval ***first*** from the U.S. Department of Health and Human Services ("HHS") for the sweeping changes they have envisioned.

The federal law is clear that Plaintiff Consumers have a statutory right to select the agency (known as a Fiscal Intermediary or "FI") they desire to administer their Medicaid services. The operative documents authorizing the Consumer Directed Personal Assistance Program ("CDPAP") in New York, which have been approved by HHS, likewise demand that consumers receiving services remain free to select their agency of choice to administer their services.

The challenged law in this case, passed in April 2024 (the "2024 CDPAP Law"), violates federal law as it eliminates the consumer's right to choose their agency, instead imposing a new statewide agency that would replace and eliminate several hundred agencies currently providing home care services, including each of the Plaintiff Agencies in this case. And it does so without any approval by HHS—let alone any attempt to even obtain such approval.

Without an injunction preventing Defendants from implementing the 2024 CDPAP Law, Plaintiff Consumers will be stripped of their right to receive care from the agency of their choice and Plaintiff Agencies will be forced to cease operations on or before April 1, 2025, resulting in irreparable harm to the Plaintiff Consumers and Plaintiff Agencies. In addition, Plaintiff Consumers—elderly, physically disabled, and/or developmentally disabled Medicaid

recipients—rely on the critical personal care services, home health aide services, and skilled nursing tasks administered by the Plaintiff Agencies. Any loss in these services because of Defendants' forced closures and contemplated transition of hundreds of thousands of beneficiaries and employees, and millions of records, to a new statewide agency, will cause Plaintiff Consumers significant and irreparable harm, including but not limited to potential forced institutionalization.

BACKGROUND

Plaintiffs consist of eighteen Medicaid beneficiaries (known as "consumers") (hereinafter, the "Plaintiff Consumers") receiving personal care, home health aide, and/or skilled nursing tasks under the CDPAP, as well as nineteen small businesses providing fiscal intermediary services (hereinafter, the "Plaintiff Agencies" or "Plaintiff FIs") to those consumers under the program. Plaintiff Consumers suffer from physical, cognitive, and/or developmental disabilities which require them to receive assistance with activities of daily living to remain in their homes and in their communities, as opposed to being placed in institutionalized care such as a nursing facility, intermediate care facility, or hospital. *See* Complaint for Declaratory and Injunctive Relief, filed August 22, 2024, Doc. 1 (hereinafter, "Compl." or "Complaint") ¶¶ 2, 15-32, 74, 115.

The CDPAP is a program designed to provide beneficiaries with "greater flexibility and freedom of choice in obtaining such services." New York Social Services Law ("NY SSL") § 365-f(1). Under the program, consumers self-direct their services, which includes recruiting and hiring their own caregivers (known as "personal assistants" or "PAs"), training, supervising, and scheduling those PAs for services, and co-employing the PAs along with the agency that they select to administer their services. Compl. ¶ 3.

Plaintiff Agencies, in turn, play an essential role in ensuring that their consumers receive the services they are entitled to receive under the program. FIs and consumers partner as co-employers of the personal assistant, and the FIs work hand-in-hand with their consumers and the PAs to facilitate the delivery of quality home care services. *Id*. ¶¶ 4-7. Importantly, Plaintiff Agencies are not simply a back-end financial service; rather, they are deemed a health care provider under the program because they play an integral role in facilitating health care services for their consumers. *Id*. ¶ 76.

In addition to ensuring PAs are timely paid in accordance with federal and state labor laws and that appropriate record-keeping of services are maintained, Plaintiff Agencies also, *inter alia*, provide training for the PAs and consumers on the program and their respective roles and responsibilities under the program, hold weekly coordination calls and scheduled assessments, conduct *ad hoc* home visits, ensure PAs report to and complete their scheduled shifts, enter into memoranda of understanding with their consumers, educate and assist their consumers in self-directing services, and continuously monitor their consumers to ensure their health status remains appropriate for self-direction of services. *See* Declaration of Rouandy Pascal ("Pascal Decl."), Ex. 1 ¶¶ 38-51; Declaration of Elena Nisnevich ("Nisnevich Decl."), Ex. 2 ¶¶ 21-27; Declaration of Alex Chadaev ("Chadaev Decl."), Ex. 3 ¶¶ 9-12. Plaintiff Agencies typically employ nursing staff and other experienced health care professionals to carry out these responsibilities. Ex. 1, Pascal Decl. ¶ 9 (employing two nurses and six administrative employees); Ex. 2, Nisnevich Decl. ¶ 7 (employing three nurses and five administrative staff).

Moreover, and critically, Plaintiff Agencies are small businesses that have formed to provide care for specific populations of beneficiaries that may not speak any English, or only speak English as a non-primary language. For example, Plaintiff Safe Haven Home Care, Inc.'s

("Safe Haven") employees speak Creole, French, and Spanish (Ex. 1, Pascal Decl. ¶¶ 10-11); Plaintiff Allcare Homecare Agency Inc. DBA Vivid Care ("Vivid Care") maintains employees that speak Urdu, Uzbek, Russian, Spanish, and Creole (Ex. 2, Nisnevich Decl. ¶ 8); and Plaintiff Carefirst CDPAP, Corp. ("Carefirst CDPAP") has employees that speak Ukranian, Georgian, Russian, and Creole (Ex. 3, Chadaev Decl. ¶ 9). These are just three examples among the nineteen Plaintiff Agencies, all of which share a similar story of addressing the unique and diverse cultural and language needs of the communities they serve. *See* Compl. ¶¶ 33-51.

Plaintiff Consumers have provided many declarations in support of this lawsuit, stressing the important role that their chosen agency plays in the delivery of their health care services, and expressing their fear of losing services and/or quality of services if forced to transition to a new statewide agency. For example, Plaintiff Violette Jeannot receives five hours of service, seven days a week, to help her manage daily tasks and medical issues due to asthma, diabetes, high blood pressure, and problems with her leg and knee. Declaration of Violette Jeannot ("Jeannot Decl."), Ex. 4 ¶ 5. Plaintiff Jeannot had negative experiences with her agency prior to receiving care through Plaintiff Safe Haven, to such a degree that it resulted in an emergency room visit due to elevated blood pressure. *Id*. ¶ 6. After switching to Safe Haven, Plaintiff Jeannot is very happy with her care. She receives visits and phone calls from the owner of Safe Haven to check in on her, Plaintiff Jeannot and her PA have benefited from counseling and advice received from Safe Haven, and the agency enables Plaintiff Jeannot to carry out her self-direction responsibilities under the program. *Id*. ¶¶ 8-19. Plaintiff Jeannot also stressed the importance of receiving these services from Safe Haven in her native language of Creole, and explained that,

"[w]ithout the ability to work with a fluent Creole speaker, [she] would not be able to manage the ongoing CDPAP requirements or handle other issues that arise." *Id*. ¶¶ 11, 17.[1]

PAs of the Plaintiff Consumers have likewise provided declarations in support of this lawsuit, illustrating the importance of remaining with the consumer's chosen agency. As an example, Anna Rozenboym serves as a PA for both of her parents, 86- and 84-year-old Holocaust survivors who immigrated to the United States from Russia. Declaration of Anna Rozenboym ("Rozenboym Decl."), Ex. 12. PA Rozenboym, along with two other PAs, provide a combined 105 hours of care for her parents, which her parents rely on to remain in their home, as a result of medical conditions that include Parkinson's disease, loss of sight, cerebral thrombosis, pulmonary embolism, autoimmune disease, kidney stones, and cerebral amyloid angiopathy. *Id*. ¶¶ 4-6. PA Rozenboym's parents chose to receive care through Plaintiff Silver Lining Homecare Agency, Inc. ("Silver Lining") because Silver Lining's office was in their community, they knew the parents of the Administrator of Silver Lining who were also Holocaust survivors, Silver Lining's employees spoke Russian, and, because of all these reasons, they felt comfortable that Silver Lining understood their unique linguistic and cultural needs. *Id*. ¶¶ 7-10. PA Rozenboym's parents have been receiving quality care through Silver Lining for more than four years and six years, respectively, and as PA Rozenboym explained in her declaration:

> My parents and I have established a comfort level with Silver Lining. This comfort, stability, and continuity is important for them, particularly as elderly people who are not English speakers and have issues with memory and anxiety. They need to know that there is a specific person whom they can contact who speaks their language, and they want to be able to communicate with the same people over the years as much as possible. Silver Lining has provided that stability for my parents and me.

[1] *See also* Declaration of Trina-Rose Cutugno ("Cutugno Decl."), Ex. 5; Declaration of Yvonne Francois, Ex. 6; Declaration of Carol Gittens, Ex. 7; Declaration of Zilla Cummings, Ex. 8; Declaration of Elizabeth Dunrod, Ex. 9; Declaration of Eugene Karasyunok, Ex. 10; Declaration of Nikolay Gavrilov, Ex. 11.

Id. ¶ 10. Forcing a new statewide agency upon PA Rozenboym and her parents "would be detrimental to [her] parents and their health care services." *Id*. ¶ 11. PA Rozenboym's "parents would be very uncomfortable talking to someone on the phone whom they did not know . . . [and] [t]he single FI plan would add to their stress and anxiety, and it would contribute to a loss of community." *Id*. ¶ 12.[2]

The 2024 CDPAP Law seeks to eliminate the nineteen Plaintiff Agencies as well as several hundred other FIs providing services in New York, and to replace all of these small businesses with one out-of-state agency that would take over the entirety of New York's ***$9 billion*** CDPAP program and serve as the ***only*** FI in the State. Compl. ¶¶ 8-10, 86-98. As discussed further below, this move, however, violates federal law because it deprives consumers of their free choice of provider and Defendants have not obtained any federal agency waiver of that applicable federal law. In addition, the transition of 246,000 Medicaid beneficiaries and their PAs from several hundred local and smaller agencies that have formed to address the specific linguistic and cultural needs of a diverse population of beneficiaries in their communities, to one centralized FI will result in loss of services and resulting institutionalizations. This will further violate several unwaivable federal laws, including laws to protect those with disabilities.

LEGAL STANDARD

To obtain a preliminary injunction, a plaintiff "must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v.*

[2] *See also* Declaration of Ana Tavarez De Acosta, Ex. 13; Declaration of Francis Paulino, Ex. 14; Declaration of Tatyana Kotsyuba, Ex. 15.

Nat. Res. Def. Council, Inc., 555 U.S. 7, 20 (2008); *see also Behihana, Inc. v. Behihana of Tokyo*, 784 F.3d 887, 895 (2d Cir. 2015) (describing four factor test); *Gairy v. City of New York*, No. 23-cv-00802, 2024 WL 1468335, at *1 (E.D.N.Y. April 4, 2024). A preliminary injunction may be "warranted on the strength of the[ ] first two factors alone." *New York v. U.S. Dep't of Homeland Sec.*, 969 F.3d 42, 86 (2d Cir. 2020).

Plaintiffs seek to maintain the *status quo ante* and therefore are seeking prohibitory preliminary relief. *Blakeman v. James*, No. 2:24-cv-1655, 2024 WL 3201671, at *6 (E.D.N.Y. Apr. 4, 2024). Plaintiffs challenge the introduction of a new law that has not yet been implemented, thus seeking to maintain "the last actual, peaceable uncontested status which preceded the pending controversy," *Hester ex rel. A.H. v. French*, 985 F.3d 165, 177 (2d Cir. 2021) (quoting *N. Am. Soccer League*, 883 F.3d at 37), by "stay[ing] 'government action taken in the public interest pursuant to a statutory or regulatory scheme,' " *Field Day, LLC v. Cnty. of Suffolk*, 463 F.3d 167, 181 (2d Cir. 2006) (quoting *Mastrovincenzo v. City of New York*, 435 F.3d 78, 88 (2d Cir. 2006)).[3]

The balance of the equities and public interest "merge when the Government is the opposing party," as in this case. *Nken v. Holder*, 556 U.S. 418, 435 (2009).

ARGUMENT

I. Plaintiffs Will Suffer Irreparable Harm Without a Preliminary Injunction

Irreparable harm is "the single most important prerequisite for the issuance of a preliminary injunction." *Faiveley Transp. Malmo AB v. Wabtec Corp.*, 559 F.3d 110, 118 (2d Cir. 2009). Plaintiffs must show that "irreparable injury is *likely* in the absence of an

[3] Even if this were considered mandatory preliminary relief, requiring a clear or substantial likelihood of success, Plaintiffs meet that standard. *New York ex rel. Schneiderman v. Actavis*, 787 F.3d 638, 650 (2d Cir. 2015).

injunction." *Winter*, 555 U.S.C at 22, 129 S.Ct. 365 (emphasis in original). Irreparable harm must be "neither remote nor speculative, but actual and imminent." *Faiveley Transp.*, 559 F.3d at 118. "The standard for preliminary injunctive relief requires a *threat* of irreparable harm, not that irreparable harm already have occurred." *Mullins v. City of New York*, 626 F.3d 47, 55 (2d Cir. 2010); *Intertek Testing Servs., N.A., Inc. v. Pennisi*, 443 F. Supp. 3d 303, 328-329 (E.D.N.Y. 2020) (quoting *Mullins*). "The relevant harm is the harm that (a) occurs to the parties' legal interests and (b) cannot be remedied after a final adjudication, whether by damages or a permanent injunction." *Salinger v. Colting*, 607 F.3d 68, 81 (2d Cir. 2010).

In the absence of preliminary injunctive relief, Plaintiffs here will suffer imminent, concrete, and irreparable harm. Defendants have already sought and obtained proposals to become the new statewide agency and anticipate a contract start date of **October 1, 2024**.[4] Moreover, under the 2024 CDPAP Law, Plaintiff Agencies will be required to close operations by April 1, 2025, and Plaintiff Consumers will be forced to transition to a single FI, possibly before April 1, 2025, and certainly no later.

Because Plaintiffs' claim under the Medicaid Statute, 42 U.S.C. § 1396a(a)(23), requires a consumer to have free choice of provider, immediately upon violation of that right, Plaintiffs will be irreparably harmed. Plaintiff Consumers' right to choose their provider is not remedied through monetary relief, nor is it fixed through an injunction that comes later, after this right has been deprived. *See Planned Parenthood S. Atl. v. Baker*, 941 F.3d 687, 707 (4th Cir. 2019) (finding that "[d]enial of [beneficiary's] right to select a qualified provider visits a tangible harm" that is irreparable and, further, that 42 U.S.C. § 1396a(a)(23) "guarantees a patient's

[4] Declaration of Derek Adams ("Adams Decl."), Ex. 16, at Appendix 1, Request for Proposals #20524.

access to her *preferred* provider, save on matters of professional integrity and competency.") (emphasis in original); *Planned Parenthood of Kan. v. Andersen*, 882 F.3d 1205, 1237 (10th Cir. 2018) (upholding district court's finding of irreparable harm from (a)(23) violation); *Bader v. Wernert*, 178 F. Supp. 3d 703, 728-729 (N.D. Ind. 2016) (finding irreparable harm where patient deprived of provider choice).

Likewise, Plaintiff Agencies will be forced to shutter FI services, in some cases representing their entire operations. Chadaev Decl. ¶¶ 13-15. Forced closure of a business—even the threat of such closure—constitutes irreparable harm. *See, e.g., Tom Doherty Assocs., Inc. v. Saban Entm't, Inc.*, 60 F.3d 27, 38 (2d Cir. 1995) ("[i]rreparable harm has been found in circumstances where a party is threatened with the loss of a business."); *see also D.M. Discoveries, Inc. v. Dutton*, CV 07-5076, 2008 WL 11471052, at *2 (E.D.N.Y. Aug. 1, 2008). Additionally, even if monetary relief were sufficient for the Plaintiff Agencies—which it is not—if a plaintiff, as is the case here, "cannot recover damages due to sovereign immunity, monetary loss may amount to irreparable harm." *Regeneron Pharms., Inc. v. U.S. Dep't of Health & Hum. Servs.*, 510 F.Supp.3d 29, 39 (S.D.N.Y. 2020).

In addition to Plaintiffs' irreparable harm from Defendants' violation of the free choice of provider provision, Plaintiff Consumers will experience additional irreparable harm from their loss of Medicaid services and/or forced institutionalization. A denial of Medicaid services "is the type of non-monetary, imminent harm that is properly characterized as irreparable." *Fishman v. Paolucci*, 628 Fed. Appx. 797, 800 (2d Cir. 2015); *Strouchler v. Shah*, 891 F. Supp. 2d 504, 522 (S.D.N.Y. 2012) ("This loss of medical care, in contravention of federal law, constitutes irreparable injury…[T]here is Second Circuit and out-of-circuit appellate law holding that the mere *threat* of a loss of medical care, even if never realized, constitutes irreparable

harm."); *Olson v. Wing* 281 F. Supp. 2d 476, 486-87 (E.D.N.Y. 2003), *aff'd*, 66 Fed. Appx. 275 (2d Cir. 2003) (Disaster Relief Medicaid recipients denied benefits and unable to obtain medical services may suffer irreparable harm without injunctive relief).

Moreover, where Medicaid recipients face the potential of being removed from their homes and institutionalized, irreparable harm exists. *See Scofero v. VNA Homecare Options, LLC*, No. 6:17-cv-06391, 2017 WL 3097612, at *6-7 (W.D.N.Y. July 21, 2017) (indicating that irreparable harm would be shown if persons "faced the potential of being removed from their homes and institutionalized, absent injunctive relief mandating the continued provision on in-home care services"); *Long v. Benson*, No. 4:08CV26-RH/WCS, 2008 WL 4571903, at *2 (N.D. Fla. Oct. 14, 2008) ("If a preliminary injunction is not issued, Mr. Griffin will run out of money and will have to move back into the nursing home. This will inflict an enormous psychological blow . . . [and] each day he is required to live in the nursing home will be an irreparable harm."), *aff'd*, 383 Fed. Appx. 930 (11th Cir. 2010); *Fair Hous. Justice Ctr., Inc. v. Cuomo*, No. 18-CV-3196, 2018 WL 4565152, at * 16 (S.D.N.Y. Sept. 24, 2018) (finding that Jane Doe established irreparable harm if required to remain in a nursing home, as opposed to her home).

Importantly, a beneficiary need not wait until institutionalization to obtain injunctive relief; rather, facing imminent institutionalization is enough. *Doxzon v. Dep't of Hum. Servs.*, No. 1:20-CV-00236, 2020 WL 3989651, at *11 (M.D. Pa. July 15, 2020). Finally, even Plaintiffs' due process claim, on its own, would be enough, as an "alleged violation of a constitutional right triggers a finding of irreparable harm." *Conn. Dep't of Env't. Prot. v. O.S.H.A.*, 356 F.3d 226, 231 (2d Cir. 2004) (quoting *Jolly v. Coughlin*, 76 F.3d 468, 482 (2d Cir. 1996)).

II. Plaintiffs Are Likely to Succeed on the Merits

To receive a preliminary injunction, the plaintiff must show that it is "likely to succeed on the merits." *Winter*, 555 U.S. 7, 20 (2008). A plaintiff need only demonstrate likelihood of success on one claim against each defendant to warrant injunctive relief. *See Navigator Bus. Servs. LLC v. Chen,* No. 23-CV-01551, 2023 WL 7386663, at *3 (E.D.N.Y. Nov. 8, 2023); *725 Eatery Corp. v. City of New York*, 408 F. Supp. 3d 424, 459 (S.D.N.Y. 2019).

Defendants, under the color of state law, are subjecting Plaintiffs to the deprivation of rights secured by the U.S Constitution and federal laws, including rights under the Medicaid Statute, 42 U.S.C. § 1396a(a)(23), to their free choice of provider, under 42 U.S.C. § 1396a(a)(8) to reasonably prompt Medicaid services, and under 42 U.S.C. § 1396a(a)(10) to entitled Medicaid services, as well as rights afforded by the Due Process Clause of the U.S. Constitution. In addition, Defendants violate Plaintiff Consumers' rights under the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 and the Rehabilitation Act of 1973 ("Rehabilitation Act"), 29 U.S.C. § 794(a).

A. Defendants Violate Plaintiffs' Right to Choose Their Provider (42 U.S.C. § 1396a(a)(23))

As explained above and in Plaintiffs' Complaint, the 2024 CDPAP Law requires Plaintiff Consumers to forgo their agency of choice, and instead accept Defendants' mandated statewide FI in order to receive Medicaid services under the CDPAP. This action, however, violates the "free choice of provider" provision of the Medicaid Statute, which requires that a state must "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from ***any institution, agency, community pharmacy, or person, qualified to perform the service or services required*** (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide

him such services." 42 U.S.C. § 1396a(a)(23) (emphasis added); *see also* 42 C.F.R. § 431.51. While this statutory right may, in certain circumstances and with appropriate justification and support, be waived by the Secretary of HHS, no such waiver has been provided to Defendants—nor have Defendants even sought such a waiver. *See* Compl. ¶¶ 62-67, 105-112, 123-127.

As a threshold matter, Plaintiff Consumers have a private right of action to enforce the free choice of provider provision in the Medicaid Statute via 42 U.S.C. § 1983. While the Second Circuit has not specifically addressed this question, all circuits that have addressed it have confirmed that the free choice of provider provision creates individual rights enforceable via Section 1983.[5] *Planned Parenthood S. Atl. v. Kerr*, 95 F.4th 152, 155-156 (4th Cir. 2024) (conducting analysis under the recent U.S. Supreme Court opinion, *Health and Hosp. Corp. of Marion Cnty. v. Talevski*, 599 U.S. 166 (2023) and finding, "we remain in the good company of four of our sister circuits and reaffirm that a Medicaid beneficiary may use § 1983 to vindicate her right under the Medicaid Act to freely choose among qualified healthcare providers"); *Planned Parenthood of Kan. v. Andersen*, 882 F.3d 1205, 1224-26 (10th Cir. 2018); *Planned Parenthood Ariz., Inc. v. Betlach*, 727 F.3d 960, 966-68 (9th Cir. 2013); *Planned Parenthood of Ind., Inc. v. Comm'r of the Ind. State Dep't of Health*, 699 F.3d 962, 974-75 (7th Cir. 2012); *Harris v. Olszewski*, 442 F.3d 456, 461-62 (6th Cir. 2006).[6] *See also Catanzano v. Wing*, 992 F.

[5] The Second Circuit has not "reach[ed] the issues of whether the Medicaid Act confers a private right to choose any qualified Medicaid provider that may be enforced through section 1983." *King v. MetroPlus Health Plan, Inc.*, No. 19-464, 2021 WL 5858923, at *2 (2d Cir. Dec. 10, 2021).

[6] The Fifth and Eighth Circuits held that a beneficiary could not challenge a provider's ***for cause*** termination based on the free choice of provider provision, but did not decide whether a beneficiary could challenge a restriction unrelated to cause under Section 1983. *Planned Parenthood of Greater Tex. Fam. Plan. & Preventative Health Servs., Inc. v. Kauffman*, 981 F.3d 347, 365, 367 (5th Cir. 2020); *Does v. Gillespie*, 867 F.3d 1034, 1038 (8th Cir. 2017).

Supp. 593, 595 (W.D.N.Y. 1998) (finding beneficiaries have a private right of action via Section 1983 for a violation of (a)(23)).[7]

The CDPAP in New York is offered under several Medicaid authorities, including the State Plan fee-for-service delivery system, a Section 1115 demonstration (managed care), and Section 1915(k) of the Social Security Act (Community First Choice Option or CFCO). Compl. ¶¶ 99-127. While the authority regimes are discussed further in the Complaint, for purposes of this motion, the salient point is that ***none*** of the currently approved regimes waives the free choice of provider provision. *Id*. To the contrary, federal authorities currently in place for New York's approvals stress that free choice among fiscal intermediaries is mandated. Compl. ¶ 125 ("CFCO participants must have a free choice of fiscal intermediaries."); ¶ 105 (under managed care authority, "[i]individuals who select self-direction must have the opportunity to have choice and control over how services are provided and who provides the service").[8]

As a result, the 2024 CDPAP Law, and Defendants' efforts to implement that law, violate federal law and Plaintiff Consumers' right to freely choose their provider.

B. Defendants Violate Plaintiff Consumers' Right to Medicaid Services (42 U.S.C. § 1396a(a)(8) & (a)(10))

The reasonable promptness provision of the Medicaid Statute, 42 U.S.C. § 1396a(a)(8), requires that a State plan must "provide that all individuals wishing to make application for medical assistance under the plan shall have the opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." The reasonable promptness mandate "requires that once an individual becomes eligible, there cannot be an

[7] While *Catanzano* also found that providers—as opposed to beneficiaries—do not have a private right of action via Section 1983 to challenge a violation of (a)(23), that question is likewise unresolved in the Second Circuit and need not be answered for purposes of the requested injunctive relief as Plaintiff Consumers clearly have standing to challenge.
[8] Adams Decl., Ex. 16, Appx. 7, at Attachment 3.1-K, p. 3; Appx. 10, at p.43.

unreasonably long wait to acquire covered care." *Ciaramella v. Zucker*, No. 18-CV-6945, 2019 WL 4805553, at *10 (S.D.N.Y. Sept. 30, 2019). This has been described by the U.S. Centers for Medicare and Medicaid Services ("CMS") as a "test of reasonableness" that depends on the "urgency of an individual's need, the health and welfare concerns of the individual, the nature of the services required, the potential need to increase the supply of providers, the availability of similar or alternative services, and similar variables." [9]

Under regulations implementing 42 U.S.C. § 1396a(a)(8), the responsible state agency must "[f]urnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures." 42 C.F.R. § 435.930(a). Therefore, for example, "a state's mismanagement of allocated funding, which leads to an unreasonable delay in the provision of services, may establish a violation of the reasonable promptness requirement." *Guggenberger v. Minnesota*, 198 F. Supp. 3d 973, 1012 (D. Minn. 2016); *see also Murphy v. Minn. Dep't of Hum. Servs.*, 260 F. Supp. 3d 1084, 1107-1108 (D. Minn. 2017) (unwarranted delay in receiving access to services due to defendants' inconsistent management of a waiver program may violate (a)(8)); *Waskul v. Washtenaw Cnty. Cmty. Mental Health*, 979 F.3d 426, 449-52 (6th Cir. 2020) (reversing dismissal of count under 42 U.S.C. § 1396a(a)(8) where plaintiffs alleged that a State's budget methodology prevented them from promptly receiving home care services).

Called the "entitlement provision" or "comparability provision," 42 U.S.C. § 1396a(a)(10) is a close cousin to the reasonable promptness mandate. While that provision focuses on the *timing* of service delivery, the entitlement provision ensures that such services are equally available to all who qualify. The entitlement provision provides that "medical assistance made available to any individual described in subparagraph (A) – (i) shall not be less in amount,

[9] Adams Decl., Ex. 16, 2001 State Medicaid Director Letter, SMDL #01-006, Appx. 4, at p. 6.

duration, or scope than the medical assistance made available to any other such individual, and (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A)." 42 U.S.C. § 1396a(a)(10)(B). This ensures that "all state Medicaid plans comply with two separate criteria: both 'that the services available to any categorically needed beneficiary … are not less in amount, duration, and scope than those services available to a *medically needed* beneficiary,' 42 C.F.R. § 440.240(a) (emphasis added), and 'that the services available to any individual in the ["categorically needy" group] are equal in amount, duration, and scope for all beneficiaries *within the group,*' *id*. § 440.240(b) (emphasis added)." *Davis v. Shah*, 821 F.3d 231, 255 (2d Cir. 2016). Denying Medicaid beneficiaries comparable access to equally needed services violates 42 U.S.C. § 1396a(a)(10). *Id.* at 259.

As a preliminary matter, while the Second Circuit has not directly addressed whether Medicaid beneficiaries may pursue a violation of (a)(8) and (a)(10) via Section 1983, all circuits that have addressed this question have answered in the affirmative.[10] District courts in New York have likewise found such a right. *Cruz v. Zucker*, 116 F. Supp. 3d 334, 345 (S.D.N.Y. 2016) (finding a private individual right under the comparability requirement of 42 U.S.C. § 1396a(a)(10)(B)). And while the Second Circuit has not squarely addressed this question, it has also suggested that such a right exists. *See K & A Radiologic Tech. Servs., Inc. v. Comm'r of the Dep't of Health of the State of New York*, 189 F.3d 273, 281 (2d Cir.1999) (discussing (a)(10) as "meant to benefit Medicaid recipients, not those providers.").

[10] *See Waskul*, 979 F.3d at 445-48 (finding language of provisions is not vague or amorphous but "sets forth criteria for determining whether those services are equitably provided," and is couched in mandatory language); *Romano v. Greenstein*, 721 F.3d 373, 377 (5th Cir. 2013); *Doe v. Kidd*, 501 F.3d 348, 356 (4th Cir. 2007); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 194 (3d Cir. 2004); *Bryson v. Shumway*, 308 F.3d 79, 88-89 (1st Cir. 2002); *Doe 1-13 by and through Doe, Sr. 1-13 v. Chiles*, 136 F.3d 709, 715-19 (11th Cir. 1998); *Watson v. Weeks,* 436 F.3d 1152, 1161 (9th Cir.2006); *S.D. ex rel. Dickson v. Hood,* 391 F.3d 581 (5th Cir. 2004).

The 2024 CDPAP Law violates both the reasonable promptness mandate and the entitlement provision. It forces Plaintiff Consumers and their PAs, along with approximately 246,000 other Medicaid beneficiaries and an even greater number of PAs, to terminate their relationship with their existing agency of choice and to reenroll and onboard with a new statewide FI that will be announced this fall. The 2024 CDPAP Law requires existing agencies to provide written notice to their consumers, personal assistants, and contracted parties at least forty-five days in advance of the April 1, 2025 end-date, on which they will be forced to close shop. NY SSL § 365-f(4-d)(a)(i). Defendant New York State Department of Health ("NYSDOH") has publicly stated that ***no transition plan*** currently exists; rather it intends to create such a plan only after awarding the new statewide contract this fall.[11] Presumably, because the 2024 CDPAP Law requires a mere forty-five days' notice, Defendants believe transitioning approximately 246,000 Medicaid beneficiaries (many of whom are non-English speakers), a greater number of PAs, and millions of medical records, from several hundred agencies to one statewide agency without massive loss of services is somehow possible within this condensed time period. It is not.

By way of example, on June 7, 2018, Washington State passed a law that would eventually transition approximately 44,000 "individual providers" (known as PAs in New York) in that state's "Consumer Directed Employer" program (known as CDPAP in New York) from employment with state-controlled Department of Social and Health Services and Area Agency on Aging offices to one contracted private vendor.[12] That transition, which pales in comparison to the one contemplated by New York in many respects (*e.g.*, 44,000 v. 246,000 beneficiaries;

[11] Adams Decl., Ex. 16, Questions & Answers, at 1106, Appx. 3.
[12] Adams. Decl., Ex. 16, Washington State Section 1915(b) Waiver Request, Appx. 5.

publicly-controlled offices transitioning to one privately-controlled agency v. several hundred privately-controlled agencies transitioning to one privately-controlled agency; 39 counties v. 62 counties), took years of careful evaluation and discussion, culminating in a March 30, 2021 submission by Washington State to HHS seeking a waiver of the free choice of provider provision to implement Washington State's plan, and resulting in an October 1, 2021 approval by HHS which permitted a geographically phased-in implementation that would take 15 months to complete.[13] In addition, hiring activities by the new agency would begin no later than 3 months prior to the beginning of the 15-month implementation period, and the new agency was required to maintain a local presence in each of the 39 counties in Washington State to facilitate the successful transition.[14]

Aside from Defendants having not created ***any*** plan for transition, nor submitted ***any*** requisite waiver requests to HHS, the 2024 CDPAP Law itself—which requires the ***completion***[15] of the transition by April 1, 2025—creates an entirely unrealistic and unworkable timeline, and one that will result in significant harm and loss of services to the 246,000 Medicaid beneficiaries utilizing the program, including the Plaintiff Consumers in this action.

New York lawmakers and those with relevant experience in other states have voiced concern regarding widespread loss of services from the impending elimination of existing

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[13] *Id*. at 5, 8.

[14] *Id*. at 11. Notably, Defendant NYSDOH will only require a local presence by the winning agency in each of the four rate regions that make up all of New York State, as opposed to each of the 62 New York counties. Adams Decl. Ex. 3, Q&A 548. And even that requirement Defendant NYSDOH "has not defined." *Id*.

[15] The 2024 CDPAP Law ***prohibits*** any agency other than the statewide FI and its subcontractors from providing FI services as of April 1, 2025. SSL § 365-f(4-a-1)(a).

agencies by April 1, 2025.[16] As relayed by the CEO of Tempus Unlimited Inc., a statewide FI operating in Pennsylvania and Massachusetts, it took Massachusetts eight months to transition 50,000 beneficiaries from two agencies to one.[17] That CEO also noted that the winning agency in New York would need to have between $600 million and $900 million just to fund the start of the program and ensure PAs continue to be timely paid, which Tempus Unlimited Inc. was unable to do, resulting in them conscientiously electing not to bid for the statewide contract in New York.[18]

Past experiences by Plaintiff Consumers also support the very real and imminent loss of services that they face and that only a preliminary injunction can prevent. As detailed in the Declaration of Plaintiff Consumer Trina-Rose Cutugno, her prior FI was terminated in 2017 by the Local District of Social Services, requiring her and 400 other consumers like her, to transition to a new FI within a short period of time. Cutugno Decl. ¶¶ 7-14, Ex. 5. This transition "required new enrollment processes: paperwork approximately 50 pages thick, gathering of identification documents, new health exams if the medical documents were not transitioned, new photos scheduled and taken 'in-person' for ID cards." *Id*. ¶ 10. Some PAs did not want to switch to a new FI because benefits varied, health insurance might have changed, and the support from the prior FI would be lost. *Id*. PAs also lost accrued PTO time and vacation time because of the required change. *Id*. ¶ 11. Many of the 400 affected consumers lost PAs during this forced transition and experienced interruption in their critical home care services. *Id*. The forced

[16] *See e.g.*, New York State of Politics, Questions mount over New York state's timeline to change Medicaid program, August 21, 2024, available at https://nystateofpolitics.com/state-of-politics/new-york/politics/2024/08/21/questions-mount-over-n-y--s-timeline-to-change-cdpap?oref=csny_firstread_nl.
[17] *Id*.
[18] *Id*.

transition itself resulted in significant trauma for those involved, because of their fear of losing critical services they rely upon to remain in their homes and communities. *Id*. ¶ 12.

As Plaintiff Cutugno explained, "[o]ur personalized training for a new PA can take weeks, sometimes months. It can take even years to really 'get in the groove' with a new PA, so they have your 'routine' down pat, and so they know how you need certain tasks done, especially for the more complex skilled tasks and care." *Id*. ¶ 9. Plaintiff Cutugno witnessed friends of hers lose PAs during this transition of 400 consumers in 2017. *Id*. ¶ 12. For example, a friend of hers that required five PAs lost two of those during the transition. *Id*. Another friend, who has cerebral palsy and associated speech impediments, lost her longtime PA who had learned to understand her well after years of working together. *Id*. The harm from this forced transition was significant, with many unable to "get out of bed, brush [their] teeth, [or] eat meals after the transition." *Id*. Plaintiff Cutugno fears that, "with the home care shortage even worse **now** than in 2017, the transition to a single statewide FI would be even **more** devastating." *Id*. (emphasis in original). If the new statewide forced transition is allowed to transpire, and notwithstanding Plaintiff Cutugno's advanced experience and knowledge, as well as her native English language skills, she still believes that it will result in the loss of "at least one PA, if not all three" currently working for her. *Id*. ¶ 14.

C. Defendants Violate Plaintiff Consumers' Rights Under the Americans with Disabilities Act and the Rehabilitation Act of 1973

Plaintiffs are likely to succeed on the merits of their claims under Title II of the ADA, 42 U.S.C. § 12132 and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a). Under the ADA, "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subject to discrimination by any such agency." 42 U.S.C. § 12132.

Similarly, under Section 504 of the Rehabilitation Act, "[n]o otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title, shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service." 29 U.S.C. § 794(a). Because of the "generally equivalent" standards under both Title II of the ADA and Section 504, courts "treat claims under the two statutes identically in most cases." *Davis*, 821 F.3d at 259 (internal quotation marks and citation omitted).

"To state a prima facie claim under either provision, a plaintiff must establish '(1) that she is a qualified individual with a disability; (2) that she was excluded from participation in a public entity's services, programs or activities or was otherwise discriminated against by a public entity; and (3) that such exclusion or discrimination was due to her disability.'" 821 F.2d at 259 (quoting *Fulton v. Goord*, 591 F.3d 37, 43 (2d Cir. 2009)). The term "disability" includes a "physical or mental impairment that substantially limits one or more of the major life activities of such an individual." 28 C.F.R. § 35.108(a). By virtue of their participation in CDPAP, a program for elderly, physically disabled and/or developmentally disabled Medicaid recipients under 18 NYCRR § 505.28, Consumer Plaintiffs are qualified individuals with a disability.

The U.S. Supreme Court, in *Olmstead v. Zimring*, 527 U.S. 581 (1999), "unquestionably holds that the 'unjustified institutional isolation of persons with disabilities' is, in and of itself, a prohibited 'form of discrimination.'" *Davis*, 821 F.3d at 260 (citing *Olmstead*, 527 U.S. at 600). Public entities, including Defendants New York State and NYSDOH (Compl. ¶ 142), must administer their programs "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d); *see also* 45 C.F.R. § 84.4(b)(2). "The

'most integrated setting' is the 'setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.'" 821 F.3d at 262 (quoting *Olmstead*, 527 U.S. at 592)). Under the integration mandate, a State must "provide community-based treatment for disabled persons when (1) 'the State's treatment professionals determine that such placement is appropriate,' (2) 'the affected persons do not oppose such treatment,' and (3) 'the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with [similar] disabilities.'" *Id.* (quoting *Olmstead*, 572 U.S. at 607)).

Following the *Olmstead* decision, the U.S. Department of Justice issued the "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*" ("DOJ Statement").[19] The DOJ made clear that a disability discrimination claim "is not limited to individuals already subject to unjustified isolation, but also 'extend[s] to persons at serious risk of institutionalization or segregation.'" 821 F.3d at 262 (quoting the DOJ Statement); Compl. ¶ 148. In addition, the DOJ Statement said that "a plaintiff could show sufficient risk of institutionalization to make out an *Olmstead* violation if a public entity's failure to provide community services or its cut to such services will likely cause a decline in health, safety, or welfare that would lead to the individual's eventual placement in an institution." DOJ Statement; Compl. ¶ 148. The Second Circuit agreed with other courts of appeals and adopted the finding that "the risk of institutionalization can support a valid claim under the integration mandate." 821 F.3d at 263 (citing cases from the Fourth, Ninth, Seventh and Tenth Circuits). The ADA and the Rehabilitation Act "provide individuals with a cause of action to challenge state's failure to administer, operate, or fund services consistent with each of those statutes' integration mandate, which failure results in

[19] Adams. Decl. Appx. 12.

segregation or risk of segregation." *M.G. v. New York State Off. of Mental Health*, 572 F. Supp. 3d 1, 14 (S.D.N.Y. 2021).

New York State specifically recognized the CDPAP as a way to address one barrier to community integration. *See* Report and Recommendations of the Olmstead Cabinet, New York State, October 2013.[20] Compl. ¶ 149. Here, the 2024 CDPAP Law will result in the elimination of several hundred FIs that serve Plaintiff Consumers and enable in-home care, allowing consumers, including Plaintiff Consumers, to remain out of institutionalized care. Compl. ¶ 150. For the same reasons discussed above regarding widespread loss of services, *see* pgs. 16-19, Defendants' implementation of the 2024 CDPAP Law will result in deprivation of in-home services and forced institutionalization, in violation of the ADA and the Rehabilitation Act. *See also* Cutugno Decl. ¶ 4 ("I needed and continue to need extensive assistance with Instrumental Activities of Daily Living, to keep me safe in the community and out of the hospital and institutions.").

D. Defendants Violate Plaintiffs' Due Process Rights

The Due Process Clause of the Fourteenth Amendment prohibits a state from "depriv[ing] any person of life, liberty, or property without due process of law." U.S. Const. Amend. XIV, § 1. Under a procedural due process claim, "the deprivation by state action of a constitutionally protected interest in 'life, liberty, or property' is not itself unconstitutional; what is unconstitutional is the deprivation of such an interest *without due process of law*." *Zinerman v. Burch*, 494 U.S. 113, 125 (1990) (emphasis in original). Courts "ask whether there exists a liberty or property interest of which a person has been deprived, and if so ... whether the

[20] Adams Decl., Ex. 16, Appx. 13.

procedures followed by the State were constitutionally sufficient." *Swarthout v. Cooke*, 562 U.S. 216 (2011).

To determine whether there have been sufficient procedural protections, courts rely on the test in *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976), weighing: "(1) the private interest that will be affected by the official action; (2) the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and (3) the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail." *Tsirelman v. Daines*, 19 F. Supp. 3d 438, 448 (E.D.N.Y. 2014) (internal citation omitted).

Plaintiff Consumers' "Medicaid benefits are a protectable 'property interest' under the Fourteenth Amendment." *Mayer v. Wing*, 922 F. Supp. 902, 910 (S.D.N.Y. 1996) (*quoting Goldberg v. Kelly*, 397 U.S. 254 (1970)). Similarly, Plaintiff Agencies have a cognizable liberty interest in their ability to carry on their business. *See, e.g.*, *Schiavone Constr. Co. v. Larocca*, 117 A.D.2d 440, 443, 503 N.Y.S.2d 196 (1986) (holding that petitioners had a cognizable liberty interest, and refusal to award them contracts had "a drastic effect upon their ability to carry on their business").

Plaintiffs' property and liberty interests were violated by Defendants *without* due process of law as Defendants' overhaul to the CDPAP program is being done without requisite federal approval, nor the public notice and hearings that are required prior to such a change. *See* 42 C.F.R. § 431.408(a)(3); Compl. ¶ 112. In sum, Plaintiffs, have demonstrated likelihood of success on the merits.

III. The Balance of Equities and Public Interest Favor Preliminary Relief

When the defendants are the government, as is the case here, the "third and fourth factors, harm to the opposing party and the public interest, merge." *Nken*, 556 U.S. at 420. Here, "an injunction would serve the public interest by preserving the individual plaintiff's statutory right under the free-choice-of-provider provision." 941 F.3d at 707; 699 F.3d at 980-981 ("The judge appropriately weighed the relative harm to the parties and the public interest and reasonably concluded that it warranted preliminary injunctive relief on the Medicaid Act claim."). In addition, equitable considerations weigh in favor of injunctive relief when loss of Medicaid services is at stake. *Olson,* 281 F. Supp. 2d at 489.

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that this Court grant their Motion for a Preliminary Injunction.

Dated: August 28, 2024

Respectfully submitted,

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EXHIBIT 1

DECLARATION OF ROUANDY PASCAL
IN SUPPORT OF PLAINTIFFS' TRO/PI MOTION

1. My name is Rouandy Pascal, I am over the age of 18 years, and I am competent to make this Declaration. I have personal knowledge of the matters set forth in this Declaration.

2. I am the CEO, administrator, and founder of Safe Haven Home Care, Inc. ("Safe Haven"), a Licensed Home Care Services Agency ("LHCSA"), as well as a fiscal intermediary ("FI") that participates in New York's Consumer Directed Personal Assistance Program ("CDPAP").

Background regarding Safe Haven

3. I founded Safe Haven in October 2008 as a LHCSA based out of Brooklyn, New York. We began serving consumers in the CDPAP on or about December 1, 2017.

4. I had worked for large home care agencies prior to founding Safe Haven but I found that the larger agencies I worked for were more interested in the bottom line than the needs of the patients they served. My philosophy has always been that the patients are at the center of what we do, and their needs come first. I sought to create an agency that was centered around the patients' needs and could be more agile and nimble, given its smaller size, to address specific needs of our patients.

5. I have been a Registered Nurse for 34 years and have worked in home health care for about 33 years. I also hold two Master of Science degrees: one in Nursing Administration and another in Nursing Informatics.

6. Safe Haven serves consumers in Bronx, Kings, New York, Queens and Richmond counties, but has remained relatively small by design. We currently serve about 62 patients through our LHCSA services and approximately 202 consumers through our FI services.

7. Because of my patient-centered philosophy, I intentionally have kept Safe Haven as a smaller, local FI in New York City, so that I can respond to each client's needs in a way that no big agency can.

8. I am closely involved in all aspects of Safe Haven's services to ensure consistent quality and foster good relationships with patients.

9. Safe Haven employs two nurses and six administrative employees.

10. Safe Haven's diverse employees serve a multicultural community. I speak English, Creole and French, and Safe Haven's employees also include Creole and Spanish speakers.

11. Safe Haven uniquely caters to the Creole and Hispanic community that includes persons from Haiti or of Haitian descent, and persons of Caribbean or Hispanic descent.

12. Because of its smaller size, Safe Haven is able to provide personal, individualized attention that has led to many happy clients and employees who refer other community members to Safe Haven.

13. Safe Haven is certified as a New York Minority- and Woman-Owned Business Enterprise (MWBE) and a Woman-Owned Business Enterprise (WBE).

Safe Haven's multiple applications to the DOH

14. While this section of my Declaration discusses events leading up to the most recent change in the law, I think it is important to provide the Court with the full context of what has transpired over the past 7 years.

15. In the 2017-2018 New York State Budget, the legislature created a new process by which FIs would need to submit a request for authorization to the New York State

Department of Health ("DOH") in order to continue providing services under the CDPAP. DOH then began a process to implement this new requirement.

16. On or about December 13, 2017, I submitted my application for authorization, consisting of 176 pages, to the DOH for Safe Haven to continue serving as an FI.

17. On or about January 2, 2019, I received confirmation from DOH that Safe Haven had met all requirements and was approved for a five-year authorization, effective December 28, 2018.

18. Subsequently, I learned that amendments to the relevant Social Services Law would eliminate the authorization process I had successfully completed and require a different process for FIs to contract with the DOH.

19. On or about March 2, 2020, I submitted an offer for Safe Haven in response to RFO number 20039, New York State Fiscal Intermediaries for the Consumer Directed Personal Assistance Program (hereinafter, the "RFO"), issued by the DOH in accordance with those amendments. Safe Haven's business model and best practices aligned with what the DOH was seeking for FIs, as stated in the RFO.

20. However, on or about February 11, 2021, I received a letter from DOH stating that Safe Haven was not selected as a contract recipient.

21. On or about February 18, 2021, I received a "written debriefing" which stated that Safe Haven had received a total score of 62.28 out of 100 total points, for a ranking of 143 out of 373 offerors.

22. On or about March 11, 2021, I attended a debriefing held by the DOH via Zoom session. Jackie McGovern from DOH led my debriefing, and she read certain comments that evaluators had made about the strengths and weaknesses of Safe Haven's offer. I recall asking

Ms. McGovern why I had received a failing score for my experience serving disabled individuals, given my extensive experience in this area. I distinctly recall Ms. McGovern saying that "some of these applications fell through the cracks."

23. I still lack an understanding today of why Safe Haven was not selected to receive a contract award, why the 68 successful offerors were chosen, and how the evaluators applied the selection criteria, assigned scores, and judged strengths and weaknesses.

24. On or about March 18, 2021, Safe Haven submitted an initial protest to the Office of the State Comptroller, challenging its non-award.

25. Safe Haven, through counsel, submitted a FOIL request to DOH for information concerning the RFO, including the technical offers received from all bidders and the scoring by each evaluator. The FOIL process led to an Article 78 proceeding that resulted in a New York state court judge ordering DOH to provide unredacted technical offers and awarding petitioners attorneys' fees.

26. The documents obtained through the FOIL process also revealed discrepancies in the scoring of Safe Haven's offer and other offers, with certain of Safe Haven's answers receiving lower scores than identical or substantially similar answers submitted by other FIs.

27. Following criticism of the RFO process, which would have resulted in only 68 FIs, the Social Services Law was amended again in April 2021 and April 2022.

28. The April 2021 amendment instructed DOH to conduct a survey of qualified offerors and make a limited number of additional awards based on objective criteria set forth in the revised statute. The supplemental awards process still relied upon DOH's initial scoring of offers, instructing DOH to award contracts to the next-highest scoring bidders who met the prescribed criteria.

29. Before any awards were made pursuant to the survey responses, the legislature amended the Social Services Law again. That April 2022 amendment provided for additional contract awards for FIs that met certain size thresholds in the first quarter of 2020.

30. Specifically, DOH was to award contracts to offerors that attested that they provided FI services for at least 200 consumers in New York City or at least 50 consumers in another area of the state, during the first quarter of 2020. However, Safe Haven serves approximately 176 consumers in New York City.

31. Since I have intentionally kept Safe Haven a smaller agency, designed to provide better quality care to our patients, Safe Haven did not meet the size requirements and did not receive an award through that process.

32. Following DOH's announcement of additional awards on June 6, 2023, Safe Haven submitted a renewed protest to the Office of the State Comptroller on June 21, 2023, challenging its non-award.

33. That protest was still pending in April 2024 when the state legislature again amended the Social Services Law and created a new procurement process whereby DOH will solicit bids for one statewide fiscal intermediary that it will select for contract.

34. Only those FIs that provide services "as a fiscal intermediary on a statewide basis with at least one other state" besides New York can apply to become the statewide FI. Safe Haven does not meet this requirement.

35. The statewide FI will be able to subcontract with existing FIs, but only if those FIs have been providing FI services since January 1, 2012 or qualified as a service center for independent living under New York law as of January 1, 2024. Safe Haven does not meet these

requirements and will not be eligible to subcontract with the statewide FI to continue providing FI services.

36. According to the amended law, Safe Haven and all FIs that do not receive subcontracts will be prohibited from providing FI services as of April 1, 2025.

Irreparable harm will result from the latest amendment

37. The shift to one statewide FI will irreparably harm the consumers served by Safe Haven, as well as Safe Haven's FI business, which will be forced to shut down by April 1, 2025.

38. Safe Haven has played a key role in its consumers' health care, ensuring they can access and receive quality CDPAP services by, among other things, facilitating payroll and withholdings, maintaining medical, personnel, and service records, and monitoring consumers' abilities to continue fulfilling their obligations under the program. Beyond those essential functions, Safe Haven also continuously connects with consumers and PAs on a personal level, in their native language, in a manner that is sensitive to their unique health concerns.

39. New consumers typically come to Safe Haven through referrals from existing patients. Particularly when consumers and PAs are new to CDPAP, another Safe Haven employee or I spend time with the consumer and PA and explain what they can expect from the program and what their respective responsibilities are.

40. During the onboarding process, another Safe Haven employee or I will visit the consumer at home to educate the consumer about supervising and managing PAs. Some consumers are very well versed in the program, while others need one-on-one help continually, which Safe Haven provides. Often, at these visits we identify other ways to improve quality of life or services for which the consumer is eligible.

41. Safe Haven also provides consumers with our handbook and enters into memoranda of understanding with consumers, both of which outline the parties' responsibilities under CDPAP. We review the memorandum of understanding with the consumer and translate it into the consumer's native language, when necessary.

42. Also, as part of onboarding, a PA typically comes to Safe Haven's office to meet with another employee or me to go over the CDPAP requirements. As a nurse, I take the PA's responsibilities very seriously, and I emphasize that the PA is being paid for authorized hours of services that the consumer needs and must provide those services reliably.

43. The CDPAP enrollment process can be stressful for consumers and their family members, especially more recently with a state Medicaid representative performing an initial independent assessment and often authorizing a minimal number of hours.

44. We seek to ameliorate that stress and establish a relationship with consumers and family members based on trust and understanding.

45. Throughout the relationship, Safe Haven provides the guidance and support that foster consumers' independence and enable consumers to fulfill their duties, for example, supporting consumers in dealing with employees, helping consumers understand their role of training and supervising their PAs, and facilitating other aspects they are expected to perform under the program. We strive to provide resources and training that empower consumers to direct their own care.

46. Safe Haven employees consistently interact with consumers and PAs. We ensure that PAs are doing the work they are paid to do—for example, a Safe Haven employee verifies that PAs are clocking in and out at consumers' homes via an electronic verification system ("EVV") and follows up with the PA and consumer by phone if necessary. If a PA does not call

into the EVV system, Safe Haven affirmatively reaches out to ensure that the PA is present and providing the agreed-upon and necessary services to their consumer.

47. Safe Haven employees conduct weekly coordination calls and scheduled assessments to ensure consumers are happy with their services and able to continue successfully directing their care. We also will conduct home visits on an *ad hoc* basis if we suspect such visits are necessary—for example to check in on a PA and ensure the consumer is receiving the care he or she deserves.

48. I provide my personal cell phone number to Safe Haven clients, and I frequently take calls at all hours from consumers and their family members regarding emergencies or other issues that arise.

49. Our consumers have grown accustomed to the quality-of-care Safe Haven provides, and I know they will not receive the same level of care if New York eliminates Safe Haven and moves to one statewide FI. A large number of our consumers have been our clients for many years at this point, and they have chosen Safe Haven as their FI and continue to choose Safe Haven as their FI. They do not want to be forced to change providers.

50. Safe Haven also provides care to a specific population of Medicaid recipients—namely, people of Haitian, Caribbean, and Hispanic descent—who have unique language needs.

51. Safe Haven's on-the-ground presence and operations, our employees' language skills, and our ability to get to know consumers and PAs, enable us to timely and effectively deliver FI services and make a tremendous difference with respect to health outcomes and quality of care for the consumers we serve.

52. I am confident that many of Safe Haven's consumers, particularly non-native English speakers, will be unable to make a successful transition to a new FI, especially a

centralized, non-local, non-culturally specific FI, that this latest change to the law will cause. A central FI will not be able to provide the specific culturally based and localized services that Safe Haven provides to its consumers and its aides. Medicaid beneficiaries served by Safe Haven will lose critical home care services because of this change.

53. I believe some of my consumers will also end up in nursing homes or other institutionalized care as a result of this change and their inability to facilitate the transition or receive ongoing assistance.

54. Safe Haven also maintains thousands of secure electronic records relating to consumers and PAs. Transferring those records to a single FI will require time, logistics, and costs, particularly if that FI uses different recordkeeping systems. This likewise will result in loss of care and services during this undoubtedly lengthy transition process.

55. Closing Safe Haven's services will cause harm to the community it serves. The state senator in the district where Safe Haven is located acknowledged the "overwhelming need" in the district for health care services among the recent Haitian immigrant community and recognized Safe Haven's "quality and culturally competent" care, in a letter to the State Comptroller dated January 9, 2023. A true and correct copy of that letter is attached as Exhibit A to this declaration.

56. Likewise, prominent community organizations expressed their appreciation for Safe Haven's valuable work and their recommendation that Safe Haven have the opportunity to continue that work. True and correct copies of those letters are also attached to this declaration, also as Exhibit A.

57. The loss of Safe Haven's ability to serve consumers, the damage to its reputation from not receiving a contract with the DOH, and the destruction of years of hard work by myself and my agency, also will result in irreparable harm to Safe Haven.

58. I have devoted countless hours and financial resources toward my dream of building an agency that provides health care services to those in need in my community. Beginning in 2008 when I applied to operate a LHCSA, through 2014 when I received a LHCSA license after working nights and weekends to submit all documentation DOH required, to the present, I worked full time and beyond and invested everything I earned over the course of thirty years into Safe Haven.

I declare under penalty of perjury that the foregoing is true and correct. Executed on 7/16/, 2024.

Rouandy Pascal

EXHIBIT A

CHAIR
SOCIAL SERVICES

COMMITTEES
CHILDREN AND FAMILIES
CITIES
DISABILITIES
LABOR
TRANSPORTATION

NEW YORK
STATE
SENATE

SENATOR ROXANNE J. PERSAUD
19TH SENATE DISTRICT

PLEASE RESPOND TO
ALBANY OFFICE:
ROOM 409 LOB
ALBANY, NEW YORK 12247
518-455-2788
FAX: 518-426-6806

DISTRICT OFFICE:
1222 EAST 96TH STREET
BROOKLYN, NEW YORK 11236
718-649-7653
FAX: 718-649-7661

EMAIL:
PERSAUD@NYSENATE.GOV

January 9, 2023

The Honorable Thomas P. DiNapoli
New York State Comptroller
110 State Street
Albany, New York 12236

Dear Comptroller DiNapoli:

I am writing with concerns regarding the possible closures of many women, minority and immigrant-owned home care agencies that have served as fiscal intermediaries for the NYS Consumer Directed Personal Assistance Program (herein CDPAP). One provider in Senate District 19, Safe Haven Home Care, Inc., located at 10526 Flatlands 1st St., Brooklyn, New York 11236, may be forced to close its doors as a result of NYS DOH RFO #20039. Since 2015, Safe Haven Home Care, Inc., has provided quality and culturally competent healthcare services to residents of Canarsie, many of whom are immigrants with limited-to-no English proficiency.

Due to the overwhelming need in Senate District 19 among the recent Haitian immigrant community, I am requesting that you give every consideration possible to Safe Haven Home Care, Inc.'s, Contract Award Protest of RFO#20039, which was submitted to your office on March 18, 2021. In December 2019, RFO#20039 was issued pursuant to the SFY 2017-2018 state budget that enacted a new requirement for agencies offering services under the CDPAP and acting as Fiscal Intermediaries, namely to apply for authorization from DOH based on the FI's "character, competence and standing in the community". To the great dismay of the healthcare community, out of 450 FI's operating in the state, contract awards were made to only 68 FI's, to provide services in all 62 counties.

In response to the inadequacy of the number of FI's, in the SFY 2022-2023 New York State Budget, the basis of the RFO contract award was changed to include any FI in New York City providing services to at least 200 consumers in the first quarter of 2020, and outside New York City, any FI providing services to at least 50 consumers. This change was needed but still does not help the Canarsie neighborhood in Brooklyn. It is estimated that some 90,000 Haitians reside in Brooklyn, mostly concentrated in the Canarsie area. Recent immigrants from Haiti are among the poorest and least educated populations in the world. Safe Haven Home Care, Inc., supports the family and community members, assisting them through a daunting maze of requirements to obtain home care. They are suffering from many serious chronic health conditions including mobility disabilities, Alzheimers, heart disease, dementia, and diabetes and many are dialysis patients. Letters received from medical professionals and community institutions describe the exemplary degree of care provided to my constituents.

Although not meeting the letter of the law, Safe Haven Home Care certainly qualifies under the spirit of the law to be awarded a contract as a Lead Fiscal Intermediary and should continue their important work here in our community. Their services are greatly needed in Canarsie. Safe Have Home Care, Inc., has received a number of commendations and letters of support from medical professionals and community-based institutions serving Canarsie.

Thank you for your consideration of this urgent matter.

Sincerely,

Roxanne J. Persaud

Roxanne J. Persaud

HNN HAITIAN NURSES NETWORK

HAITIAN NURSES NETWORK, INC

December 19, 2022

To Whom It May Concern,

The mission of Haitian Nurses Network is to promote professional excellence and contribute to impactful outcomes in healthcare and society. We empower nurses and other Healthcare Professionals to provide resources and create opportunities to improve the lives of under-served and under-privileged populations.

Our non-profit services include the following -

- ☐ Free mammogram
- ☐ Free blood test
- ☐ Free health screening
- ☐ Free Blood pressure screening

Recent immigrants from Haiti are among the poorest and least educated populations in the world. In Brooklyn, current estimates are that we have 90,000 Haitians residing here, mostly concentrated in the Canarsie area. We have been working with Nurse Rouandy Pascal, CEO of Safe Haven Home Care, since early 2016. The important services and knowledge she bring to

501c3 healthcare organization www.myhnn.org haitiannursesnetwork7@gmail.com (347)636-4005
1817 Flatbush Ave Brooklyn NY 11210

HNN HAITIAN NURSES NETWORK

HAITIAN NURSES NETWORK, INC

the community is greatly appreciated.

Seniors require many diverse services, according to their individual situations. Safe Haven Home Care works with the Medicaid population who have chronic health conditions, requiring home health aides. When seniors cannot find suitable home health aides, those services are performed by family or community members. Safe Haven Home Care supports these seniors, assisting them through the maze of requirements to obtain home care.

Our organization recommends that Nurse Rouandy Pascal and Safe Haven Home Care be given the opportunity to continue their work in Canarsie Brooklyn. They are a valuable part of our community of health care providers for seniors.

Thank you for considering our request.

With regards,

Dr. Marie Guerline Paul

President

501c3 healthcare organization www.myhnn.org haitiannursesnetwork7@gmail.com (347)636-4005
1817 Flatbush Ave Brooklyn NY 11210

United Church of Faith
643 E 88th street
Brooklyn, N.Y. 11236
Tel: (718) 613-9944

December 19, 2022

To whom it may concern,

United Church of Faith is located in Canarsie, Brooklyn, in the heart of the Creole speaking Haitian community - especially recent immigrants here in New York.

At United Church of Faith, we pride ourselves on building bridges within our community. We assist the elderly and neediest in our community by operating a Food Pantry every Saturday, as well as a free clothes and coats program.

As such we regularly interact with agencies that offer services to the same population. Since 2015, Safe Haven Home Care has been serving the elderly Medicaid population here in Canarsie. Among recent immigrants from Haiti, there is a high level of illiteracy, poverty, and lack of knowledge and experience with modern health care. Nurse Rouandy Pascal and Safe Haven Home Care has been providing home care to a large number of our congregation. In addition, Safe Haven Home Care has employed numerous congregation members as home care aides. This opportunity for recent Creole speaking immigrants is very important here in Canarsie.

Safe Haven Home Care goes above and beyond by also providing free of charge, assistance for Medicaid eligibility and food stamps. They work hand in hand with us just like a community non-profit.

Safe Haven Home Care focuses on the population with chronic illnesses requiring home health aides. These in home services are an important part of health care requirements in our neighborhood. Our home bound neighbors need care.

Based on their excellent record of service, we recommend that Safe Haven Home Care be given the opportunity to continue their work here in Canarsie, Brooklyn.

Sincerely,

Benjamin Michelet

Pastor Benjamin Michelet

ORIGIN OCCUPATIONAL & PHYSICAL THERAPY
5303 Avenue N Brooklyn NY 11234
TEL 718 676-0584

December 19, 2022

To Whom It May Concern,

I am an Occupational Therapist in Canarsie, Brooklyn area with over 33 years experience. As a Director of Origin OT and PT I have been collaborating with Safe Haven Home Care since 2019,. This home care services has provided and continued to provide excellent and skilled care services for the elderly Medicaid population here in Canarsie .

Please let it be noted , there is a high level of illiteracy, poverty, and lack of knowledge and experience with modern health care in the recents immigrants from Haiti .Needless to say, this community as a unique language group is quite reluctant to speak with anyone who does not speak Haitian Creole due to cultural and language barriers. I believe Safe Haven Home Care has the knowledge , competence , and necessary skills and staffing in assisting this population within this specific community

I do find that the CDPAP program is appropriate for the needs of the elderly in the Haitian community. In addition, Safe Haven Home Care supports these seniors, assisting them through the maze of requirements to obtain home care. Without Safe Haven services not only these patients' health can deteriorate but not having the CDPAP program might have an added burden to their families and at large the community .

I highly recommend that Safe Haven Home Care be given the opportunity to continue their work here in the Canarsie area of Brooklyn.

With regards,

Marcel Picard, OTR/L Supervisor

Marcel Picard OTR /L

Dr. Daniel Dume-Charles
1602 Avenue L
Brooklyn. N.Y 11236
Tel: (718) 444-0437

December 19, 2022

To Whom It May Concern,

I practice Family Medicine in the Canarsie area of Brooklyn with over 25 years' experience in the field of medicine. I have worked with Nurse Rouandy Pascal and Safe Haven Home Care since 2015 and have found them to be an excellent provider of home care services.

In our area, we both work with the underserved Haitian community, which is a unique language group. Among recent immigrants from Haiti, there is a high level of illiteracy, poverty, and lack of knowledge and experience with modern health care. Safe Haven Home Care are experts in working with the Haitian community and are also members of the community.

Seniors require many diverse services, according to their individual situations. Safe Haven Home Care works with the Medicaid population who have chronic health conditions, requiring home health aides. When seniors cannot find suitable home health aides, those services are performed by family or community members. Safe Haven Home Care supports these seniors, assisting them through the maze of requirements to obtain home care.

I recommend that Safe Haven Home Care be given the opportunity to continue their work here in Canarsie section of Brooklyn.

Sincerely,

Dr. Daniel Dume-Charles

Daniel Dume-Charles MD
LIC # 220943
:MEDICINE

EXHIBIT 2

DECLARATION OF ELENA NISNEVICH
IN SUPPORT OF PLAINTIFFS' TRO/PI MOTION

1. My name is Elena Nisnevich, I am over the age of 18 years, and I am competent to make this Declaration. I have personal knowledge of the matters set forth in this Declaration.

2. I am the administrator and director of Allcare Homecare Agency Inc. DBA Vivid Care ("Vivid Care"), a Licensed Home Care Services Agency ("LHCSA"), as well as a fiscal intermediary ("FI") that participates in New York's Consumer Directed Personal Assistance Program ("CDPAP").

3. I have a Bachelor of Science with a major in mathematics and a minor in computer and information science. I have a Master's degree in medical informatics.

Background regarding Vivid Care

4. Vivid Care was founded around September 2016 as a LHCSA based in Brooklyn, New York. Vivid Care began serving consumers in the CDPAP on or about October 1, 2016.

5. Vivid Care serves consumers in the New York Metropolitan area (Manhattan, Bronx, Brooklyn, Queens and Staten Island) as well as Nassau County. Approximately 45-50% of our consumers participate in CDPAP. Vivid Care employs (or jointly employs) approximately 350 home health aides ("HHAs"), personal care aides ("PCAs"), and personal assistants ("PAs"). About one-half of those employees are PAs who provide service under CDPAP.

6. CDPAP was particularly critical during the COVID-19 pandemic as many of our LHCSA clients felt uncomfortable having non-family members in their homes for care. Therefore, many clients switched from LHCSA services to CDPAP under which a family member provided care during the pandemic. A number of those clients have remained in CDPAP with a family member still providing care given the positive experience with CDPAP and our FI services.

7. Vivid Care employs five administrative employees in the office who serve in Human Resources and as Coordinators. Vivid Care employs three nurses part-time.

8. Vivid Care's diverse employees serve a multicultural community and speak English, Russian, Spanish, Uzbek, Urdu and Creole.

9. Because Vivid Care is centrally located in the community, consumers and their PAs often come into the office for assistance with requirements for participation in CDPAP. For example, although the required sexual harassment training and electronic verification system ("EVV") training are online, many PAs still come to the office for help. Many consumers and PAs are not computer savvy and benefit from being able to visit the office.

10. Staff at Vivid Care help those PAs and consumers understand their respective obligations under the program, as well as the importance of accurate time reporting and consistent and quality care to be delivered to the consumers.

Vivid Care's multiple applications to the DOH

11. On or about March 1, 2020, I submitted an offer for Vivid Care in response to RFO number 20039, New York State Fiscal Intermediaries for the Consumer Directed Personal Assistance Program (hereinafter, the "RFO"), issued by the DOH. Through the RFO, DOH sought to award contracts to certain FIs participating in the program.

12. On or about February 11, 2021, I received a letter from DOH stating that Vivid Care was not selected as a contract recipient. I understand that 68 FIs were originally selected in this first round of awards.

13. Following criticism of the RFO process, the Social Services Law was amended in April 2021 and April 2022. The April 2022 amendment provided for additional contract awards for FIs that attested to serving a certain number of consumers in the first quarter of 2020.

14. Being a smaller FI serving approximately 75 consumers in New York City during the first quarter of 2020 (and 160 consumers currently), Vivid Care did not meet the size requirements of at least 200 consumers and did not receive an award through the attestation process.

15. The DOH announced additional awards pursuant to the attestation process on June 6, 2023, and Vivid Care challenged its non-award by submitting a protest to the Office of the State Comptroller on June 21, 2023.

16. That protest was rendered moot by the April 2024 amendment to the Social Services Law creating a new procurement process whereby DOH ultimately will contract with a single statewide fiscal intermediary.

17. Only an FI that provides services "as a fiscal intermediary on a statewide basis with at least one other state" besides New York can apply to become the statewide FI. Vivid Care does not meet this requirement.

18. The statewide FI will be able to subcontract with existing FIs, but only if such subcontractors have been providing FI services since January 1, 2012 or qualified as a service center for independent living under New York law as of January 1, 2024. Vivid Care does not meet these requirements and will not be eligible to subcontract with the statewide FI to continue providing FI services.

19. According to the amended law, Vivid Care and all FIs that do not receive subcontracts will be prohibited from providing FI services as of April 1, 2025.

Irreparable harm will result from the latest amendment

20. The shift to one statewide FI will irreparably harm the consumers served by Vivid Care, as well as Vivid Care's FI business, which will be forced to close its CDPAP operations by April 1, 2025, and lose hundreds of its employees and consumers.

21. Vivid Care provides personal, on-the-ground services and helps consumers maximize their health and well-being through access to CDPAP services.

22. Vivid Care's ability to speak the language of its consumers and employees, and meet with them face-to-face when needed, is critical to assisting consumers with the performance of their responsibilities under the program, and ensuring that they are able to continue fulfilling those responsibilities.

23. Our agency assists new consumers on how the process to enroll in CDPAP works, such as facilitating setting up an independent assessment through Maximus. We memorialize the parties' respective CDPAP responsibilities in a memorandum of understanding when a consumer first comes to Vivid Care, and we review that MOU with the consumer at his or her home—both initially and annually—and address any questions. This is done in the consumer's native language where necessary, to ensure the consumer understands his or her legal obligations.

24. Likewise, we meet with new PAs in our offices to explain, in their native language, the CDPAP, their responsibilities, and various laws that apply to their work, wages, and benefits.

25. We provide efficient turnaround times to onboard a PA who would be providing essential care to a CDPAP consumer. We also provide essential reminders to current PAs to ensure continuity of care, such as tracking annual physical requirements and reminding PAs two months in advance of the deadline.

26. Every consumer has a dedicated case manager at Vivid Care—often someone who speaks the same language as and shares the cultural background of the consumer and PA. The Vivid Care case managers regularly communicate with their assigned consumers to learn about the consumers and their needs, abilities, family dynamics, and health status, and to ensure the consumers can continue to direct their care.

27. Through our dedicated case managers and our accessible office in Brooklyn, consumers are connected to our agency and supported as they direct their care. Our training for consumers assists them in employing and managing their PAs, including how to effectively supervise them and manage difficult situations. Vivid Care's operations and best practices track what the DOH initially sought in the RFO.

28. Our consumers benefit from Vivid Care's quality of care and local presence, and they will not receive the same level of care from a single statewide FI.

29. I am confident that many of Vivid Care' consumers, particularly non-native English speakers, will be unable to make a successful transition to a new statewide FI that is not able to provide the specific culturally based and localized services that Vivid Care provides to its consumers and the Personal Assistants. Many consumers will lose critical home care services because of this change, and some will be forced to turn to nursing homes or other institutionalized care.

30. Vivid Care also maintains thousands of secure electronic records relating to consumers' health and PAs' employment and payroll. The time and cost associated with transferring those records to a single FI are likely to result in a loss of services during the lengthy transition.

31. All of these impending changes threaten irreparable harm to Vivid Care's consumers and PAs, and to Vivid Care itself.

I declare under penalty of perjury that the foregoing is true and correct. Executed on August 14, 2024.

Elena Nisnevich

EXHIBIT 3

DECLARATION OF ALEX CHADAEV

1. My name is Alex Chadaev, I am over the age of 18 years, and I am competent to make this Declaration. I have personal knowledge of the matters set forth in this Declaration.

2. I am the co-founder and CEO of Carefirst CDPAP, Corp. ("Carefirst"), a fiscal intermediary ("FI") that participates in New York's Consumer Directed Personal Assistance Program ("CDPAP").

3. My business partner and I founded Carefirst in 2017. Prior to that I had worked at an HMO company, for a licensed home care services agency, and for a home health care agency. Those experiences gave me the information and contacts I needed to provide great service via my own agency.

4. My business partner is also a veteran in the home health care field with more than 20 years of experience. We joined forces to open Carefirst, working together with no outside help or financial assistance.

5. I knew how badly people needed CDPAP services, so I put everything into opening and running Carefirst, investing a significant amount of my own resources and time. I put all of my savings into the agency, and my co-founder withdrew money from her retirement account to start the business.

6. It took about one year to apply and qualify for a license to operate Carefirst as an FI. We started off small with a single client but gradually got more contracts and clients. Our consumers come to Carefirst primarily through word of mouth, from other satisfied consumers. Carefirst now serves approximately 130 consumers and approximately 200 personal assistants ("PAs").

7. Carefirst has a good reputation for making sure PAs are fully compensated and paid on time. We have a solid record of working with consumers and PAs and delivering on what we promise, and that also shows in the absence of complaints or litigation against Carefirst.

8. Carefirst has three locations in Nassau, Queens, and the Bronx, and it has a wide geographical reach, serving consumers in the Five Boroughs, Nassau, and underserved areas of Suffolk, Richmond, and Westchester counties.

9. Carefirst also has a wide diversity of clients. We embrace and respect every culture and consumer, work within the framework of people's cultural needs, and accommodate religious restrictions. Our consumers include Creole, Ukrainian, Georgian, and Russian speakers. As an example, we have even helped a consumer who spoke a different language and was unable to read and write access services.

10. Although my title is CEO, I wear many hats and help with everything related to the business. The service coordinator function suits me most, as I enjoy visiting patients' homes and meeting with PAs. I know almost all our consumers by name and have gotten to know them through face-to-face interactions. I know what they are struggling with, and the consumers appreciate that.

11. When a consumer needs to change PAs, Carefirst makes that change right away. When a consumer is hospitalized, I call their family members to coordinate getting that consumer more help. When a consumer or PA has questions, they can reach us and receive a response quickly. We are on the ground, helping consumers and PAs.

12. Consumers are happy with Carefirst's services. We have clients who have been with us since the beginning, for seven years, and who have no intention of switching FIs.

13. Carefirst's sole line of business is its FI operations. The planned shift to one statewide FI will irreparably harm the consumers served by Carefirst, as well as Carefirst's FI business, which will be forced to shut down by April 1, 2025.

14. I opened Carefirst and remained in this business to provide services. I have invested countless hours and resources in the agency and essentially put all my eggs in this basket. If Carefirst is forced to close, I will go bankrupt and need to file for unemployment benefits, and my family will be affected as well.

15. Carefirst's closure would also harm my co-founder and our office staff. The destruction of our business, which we have worked so hard to build and desire to continue operating to serve consumers, will irreparably harm Carefirst.

16. Likewise, Carefirst's consumers will lose the quality of care that Carefirst provides. Our consumers are anxious about the planned changes. They are happy with their current FI and do not want to switch.

17. I believe that consumers' care will be greatly diminished if New York moves to a single statewide FI. I am also confident that many of Carefirst's consumers will be unable to successfully transition to a new FI. A large statewide FI will not be able to provide the on-the-ground, culturally sensitive services that Carefirst does. As a result, consumers will lose critical home care services and some will end up in nursing homes or other care facilities.

18. Additionally, Carefirst maintains thousands of secure electronic records relating to consumers and PAs. Transferring those records to a single FI will require time, logistics, and costs, particularly if that FI uses different recordkeeping systems. This likewise will result in loss of care and services during this undoubtedly lengthy transition process.

I declare under penalty of perjury that the foregoing is true and correct. Executed on 08/26/2024, 2024.

Alexander Chadaev

Alex Chadaev

EXHIBIT 4

DEKLARASYON VIOLETTE JEANNOT

1. Mwen rele Violette Jeannot, mwen gen plis pase 18 lane, epi mwen konpetan pou m fè Deklarasyon sa a. Mwen gen konesans pèsonèl sou zafè ki presize nan Deklarasyon sa a.

2. Mwen abite nan Brooklyn epi m resevwa swen lakay mwen dapre Pwogram New York Èd Swen Pèsonèl Konsomatè Dirije (Consumer Directed Personal Assistance Program, "CDPAP").

3. Yo te jwenn mwen kalifye pou m resevwa sèvis CDPAP paske m kalifye tou pou asistans medikal anpasan pa Medicaid epi m kalifye pou swen dire long oswa swen pèsonèl.

4. Pwofesyonèl medikal ak pwofesyonèl tretman yo nan Eta New York te detèmine sèvis nan kay ak nan kominote apwopriye pou mwen, epi mwen anfavè sèvis sa yo. Jiskaprezan, Eta a te pran anchaj sèvis nan kay mwen yo yon fason rezonab.

5. Se nyès mwen ki èd pèsonèl mwen (Personal Assistant, "PA") nan kad CDPAP. Li travay pou mwen pandan senk èdtan pa jou, sèt jou sou sèt pou ede m jere travay toulejou yo ak pwoblèm medikal mwen genyen akòz opresyon, dyabèt, tansyon wo, epi pwoblèm nan janm mwen ak nan jenou m. Nyès mwen pran swen m trè byen.

6. Anvan m te enskri nan CDPAP, mwen te resevwa èd anpasan pa yon ajans swen pèsonèl, men m te gen anpil pwoblèm ak plent. Èd ajans lan te voye yo pa te kapab ede pou tout travay mwen te bezwen yo, epi responsab ka ki te afekte pou mwen an te malelve e li pa te fè okenn ka de mwen. Nan yon sèten moman, lè m t ap fè fas ak ajans swen pèsonèl la epi m te trè fache ak yo, tansyon m te monte tèlman wo mwen te ale nan sèvis dijans.

7. Nan estad sa, yon zanmi ki te konnen sitiyasyon m te rekòmande pou m ale nan swen CDPAP ak Safe Haven.

8. Eksperyans mwen ak Safe Haven kòm entèmedyè fiskal mwen (Fiscal Intermediary, "FI") ak PDG li a, Rouandy Pascal, te fè m tèlman kontan. Mwen pa gen okenn

plent konsènan Safe Haven ak sèvis yo ban m yo, epi m apresye toutbon fason Madam Pascal trete m.

9. Lè m te enskri nan CDPAP epi nyès mwen te kòmanse kòm PA mwen, Madam Pascal te pale avèk nyès mwen an sou enpòtans pou pran swen m epi ki travay li te dwe fè pou mwen.

10. Epitou Madam Pascal te vizite kay mwen de fwa pou eksplike pwogram lan. Mwen resevwa toujou yon koutfil Madam Pascal chak mwa pou l wè kijan m ye epi pou konfime m ap resevwa sèvis mwen yo.

11. Sa ki trè enpòtan tou, Madam Pascal te bay tout sèvis sa yo nan lang Kreyòl natifnatal mwen. San kapasite pou travay avèk yon moun ki pale kreyòl trè byen, mwen pa t ap kapab jere egzijans aktyèl CDPAP yo ni jere lòt pwoblèm ki prezante. Kapasite lang sa yo te fè yon diferans pou mwen lè m te seleksyone Safe Haven kòm FI mwen.

12. Anplis li ede m jere travay PA mwen an ak sèvis CDPAP mwen resevwa yo, Safe Haven akòde m anpil atansyon pèsonèlman. Mwen santi yo trè pran swen m, epi anplwaye yo ban m lespwa.

13. Safe Haven te pran dispozisyon anplis pou pran swen m pandan pandemi Covid-19 la, li te tcheke kòman m ye pou asire m te gen asistans ansanm ak lòt nesesite yo, epi li te konseye m sou sa pou m fè si m santi m malad oswa si m te bezwen èd.

14. Mwen kwè okenn lòt moun pa ka bay nivo swen Madam Pascal ak Safe Haven bay yo. "Safe Haven" (refij an sekirite) se yon bon non vre — FI a ak anplwaye li yo pran swen tout moun trè byen.

15. Mwen konprann Depatman Sante a ap planifye pou fè kontra avèk yon sèl FI nan tout Eta a epi m pa t ap kapab itilize Safe Haven ankò kòm FI mwen.

16. Chanjman sa a menase lakòz yon gwo mal pou mwen ak pou fanmi m.

17. Safe Haven trete m byen, epi FI an tou genyen moun ki gen konpetans nan lang ki nesesè pou m jwenn aksè nan sèvis CDPAP mwen yo. Si moun mwen dwe kominike avèk yo a nan yon nouvo FI pa pale Kreyòl, mwen pa konnen kisa m ap fè. Mwen pè pou m ta fini pa pèdi sèvis CDPAP mwen yo paske mwen pa t ap kapab navige nan tranzisyon an san yon moun ki pale Kreyòl pou ede m. Fè yon twazyèm pati eseye tradui regilyèman pa t ap mache byen nonplis paske anpil bagay pèdi pandan tradiksyon.

18. Mwen apresye endepandans ki akonpaye viv lakay la; mwen apresye dèske m resevwa swen nan men yon PA mwen te chwazi; epi m apresye relasyon m genyen avèk Safe Haven ak anplwaye li yo ke m fè konfyans pou anplwaye nyès mwen an ansanm ak mwen epi ede m pran responsablite m nan pwogram lan. Bagay sa yo te gen enpak pozitif sou sante m ak lavi toulejou m.

19. Antanke konsomatè CDPAP, li enpòtan pou m chwazi yon FI ki ede m reponn ak responsablite mwen yo. Si m te gen lechwa, mwen t ap kontinye resevwa sèvis CDPAP yo lakay mwen, ke Safe Haven ak nyès mwen bay.

20. Mwen te egzamine e apwouve tèks tradiksyon sètifye Deklarasyon an kreyòl sa a anvan mwen siyen ni vèsyon Kreyòl ni vèsyon Anglè Deklarasyon an.

Avèk posiblite sanksyon pou fo temwayaj, mwen deklare sa ki endike anwo la a vre e kòrèk. Siyen nan dat 7/15, 2024.

Violette Jeannot

Violette Jeannot

DECLARATION OF VIOLETTE JEANNOT

1. My name is Violette Jeannot, I am over the age of 18 years, and I am competent to make this Declaration. I have personal knowledge of the matters set forth in this Declaration.

2. I live in Brooklyn and receive care in my home under New York's Consumer Directed Personal Assistance Program ("CDPAP").

3. I was deemed eligible to receive CDPAP services because I am also eligible for medical assistance through Medicaid and eligible for long term care or personal care.

4. Medical and treatment professionals in New York State have determined that home- and community-based services are appropriate for me, and I favor such services. Thus far, the State has reasonably accommodated my home-based services.

5. My niece is my personal assistant ("PA") under the CDPAP. She works for me for five hours a day, seven days a week to help me manage daily tasks and medical issues due to asthma, diabetes, high blood pressure, and problems with my leg and knee. My niece takes care of me very well.

6. Before I enrolled in CDPAP, I received assistance through a personal care agency but had many problems and complaints. The aides that the agency sent could not help with all the tasks I needed, and the case manager assigned to me was rude and dismissive. At one point when I was dealing with the personal care agency and very upset with them, my blood pressure rose so high that I went to the emergency room.

7. At that point, a friend who knew about my situation recommended that I move to CDPAP care and Safe Haven.

8. My experience with Safe Haven as my fiscal intermediary ("FI") and with its CEO, Rouandy Pascal, has made me so happy. I have no complaints about Safe Haven and the services they have provided me, and I am so appreciative of the way Ms. Pascal treats me.

9. When I enrolled in CDPAP and my niece started as my PA, Ms. Pascal spoke to my niece about the importance of taking care of me and what work she needed to do for me.

10. Ms. Pascal also visited my home twice to explain the program to me. I still receive a monthly phone call from Ms. Pascal to see how I am doing and to confirm that I am receiving my services.

11. Crucially, Ms. Pascal provided all these services in my native language, Creole. Without the ability to work with a fluent Creole speaker, I would not be able to manage the ongoing CDPAP requirements or handle other issues that arise. These language abilities made a difference to me when selecting Safe Haven as my FI.

12. In addition to helping me manage the employment of my PA and the CDPAP services I receive, Safe Haven gives me personally a lot of attention. I feel very cared for, and the employees give me hope.

13. Safe Haven took extra steps to take care of me during the Covid-19 pandemic, checking in with me to make sure I had assistance and other necessities and advising me what to do if I felt sick or needed help.

14. I believe that no one else could provide the level of care that Ms. Pascal and Safe Haven do. "Safe Haven" is the right name—the FI and its employees take care of everyone very well.

15. I understand that the Department of Health is planning to contract with a single statewide FI and that I would no longer be able to use Safe Haven as my FI.

16. This change threatens to cause me and my family great harm.

17. Safe Haven treats me so well, and the FI also has people with the language skills that are necessary for me to access my CDPAP services. If the people I must interact with at a new FI do not speak Creole, I don't know what I would do. I am afraid I would end up losing my CDPAP services because I would be unable to navigate the transition without a Creole speaker to help me. Having a third party to try and translate on a regular basis would not work well either as so much is lost in translation.

18. I value the independence that comes with living at home; I value receiving care from the PA to whom I have chosen; and I value my relationship with Safe Haven and its employees whom I trust to co-employ my niece with me and to help me carry out my responsibilities under the program. These things have had positive impacts on my health and my daily life.

19. As a CDPAP consumer, it is important to me to choose the FI that helps me carry out my responsibilities. If I had my choice, I would continue to receive CDPAP services in my home, provided by Safe Haven and my niece.

20. I reviewed and approved the text of the certified Creole translation of this Declaration before signing both the Creole and English versions of the Declaration.

I declare under penalty of perjury that the foregoing is true and correct. Executed on 7/15, 2024.

Violette Jeannot

Violette Jeannot

CERTIFICATE OF TRANSLATION

I, Patrick Paul, am fluent in the Creole and English languages. I have been translating documents for 20 years and am competent to translate documents from English into Creole. I hereby certify that the document identified below that was translated from English into Creole, and is true and accurate, to the best of my knowledge and belief.

Reference:
CDPAP 365-f challenge - V. Jeannot declaration draft 6-26
CDPAP 365-f challenge - Y. Francois declaration draft 6-26

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Signature

Patrick PAUL

Name

July 05, 2024

Date

Employer: Independent Contractor / Hired by TransPerfect Translations, Inc.

Employer Address: 1250 Broadway, 7th Floor, New York, NY 10001

Phone Number: 646.357.3196

EXHIBIT 5

DECLARATION OF TRINA-ROSE CUTUGNO

1. My name is Trina-Rose Cutugno, I am over the age of 18 years, and I am competent to make this Declaration. I have personal knowledge of the matters set forth in this Declaration.

2. I am a Medicaid beneficiary. I receive home care services authorized through my local district of social services, Human Resources Administration ("HRA") in New York City, fee-for-service, because I am in the Nursing Home Transition & Diversion Medicaid Waiver program, and thus exempt/excluded from managed care and managed long term care ("MLTC") plans. My Fiscal Intermediary ("FI") is Chinese-American Planning Council. I have three Personal Assistants and am authorized for 84 hours of services under the Consumer Directed Personal Assistance Program ("CDPAP") per week.

3. I have a form of skeletal dysplasia – a bone disorder which leaves me prone to fractures at my joints, osteoarthritis and limited range of motion. I am also a little person, and I have significant needs in the areas of instrumental activities of daily living including laundry, shopping, cooking and cleaning and ADL needs like dressing, putting on my shoes, etc. I use adaptive equipment, canes and wheelchairs for mobility, and I've used homecare in various models for over 15 years.

4. Home care helps me protect my joints. Prior to getting home care, my shoulder joints and knee joints would fracture just simply carrying my laundry bag up my apartment stairs, or climbing up on step stools in my kitchen to handle and transfer my boiling hot pot of water for pasta to the strainer at the sink, or reaching for vegetables far too out of reach for me at the supermarket, having to knock cans of peas off the shelves with my cane while ducking so it didn't hit me in the head. I needed and continue to need extensive assistance with Instrumental Activities of Daily Living, to keep me safe in the community and out of the hospital and institutions.

5. Home care also helps me to be a ***part*** of my community, where I volunteer and vote, laugh and love, tread and travel.

6. Years prior to my enrolling in CDPAP, I used the traditional model of home care, where the agency scheduled, trained, and sent workers to my home. The problem I kept running into is that when my needs changed, so did my home care agencies(!). This is because each home care agency had different licenses and "scope of tasks" that they were authorized to provide, (i.e. CHHA, housekeeping, Home Attendant, etc.), and so I experienced a constantly changing environment in my home. It became quite exhausting to experience the staff turnover, "no shows" of Personal Care Assistants, Home Attendants and Home Health aides, nurses, etc., and constantly losing the continuity of an established relationship with the workers as well as the agencies when my own health needs fluctuated. For this reason, I turned to CDPAP, where I have now been for over 10 years, initially beginning with Concepts of Independence.

7. Something significant happened in June 2017. In my mailbox, I received a letter from the Local District of Social Services (HRA in NYC), stating "*The Fiscal Intermediary services that Concepts of Independence provides to you will end on 6/30/17*" and I would have to "*select a new Fiscal Intermediary.*" Further, the letter stated: "*In addition, your Personal Assistants must register with your new fiscal intermediary by June 16th in order to receive wages after June 30th, 2017*." This was because my CDPAP FI was no longer contracted with NYC HRA's contract division.

8. I later learned, through my informal network of disability communities and advocate families, that I was one of **400 consumers** in NYC affected by this. The 400 consumers were vulnerable New Yorkers like myself, who, because of the complexities of our needs, were kept out of "managed care" (1115 waiver, the experimental financing demonstration) because we

were: Nursing Home Transition & Diversion Medicaid Waiver participants, folks with intellectual & developmental disabilities in the OPWDD Waiver, Traumatic Brain Injury Waiver participants, folks in hospice, folks who are temporarily exempt from managed care due to completing a course of treatment with a specialist who is not in managed care. I bring to light the populations that were affected by this because it seemed that no one other than us experiencing it, truly understood the harm that this transition had on us. In the trauma of it, we felt unheard and unseen and only had each other to rely on for information, through phone calls and email listservs and the like.

9. We didn't know **why** this was happening to us, and what would happen to us if our Personal Assistants decided NOT to follow us over to a whole new agency. That's because we had to rely on each of our PAs' loyalty to us as consumers to continue working with us throughout the transition, especially for such low wages, and we hoped that the new slew of administrative paperwork wouldn't deter them away into more lucrative and perhaps less stressful jobs. We were scared, and with good reason: It's hard to find new PAs! Our personalized training for a new PA can take weeks, sometimes months. It can take even ***years*** to really "get in the groove" with a new PA, so they have your "routine" down pat, and so they know ***how*** you need certain tasks done, especially for the more complex skilled tasks and care.

10. Switching FIs required new enrollment processes: paperwork approximately 50 pages thick, gathering of identification documents, new health exams if the medical documents were not transitioned, new photos scheduled and taken "in-person" for ID cards. Some of our Personal Assistants didn't want to register with a whole new FI, since the benefits varied, the health insurance would be different, and the "support" that we had with our current FI staff would be lost.

11. We were all initially given just 10 days to switch our fiscal intermediary, and have all of our PAs switch over to a new fiscal intermediary *(losing their accrued PTO time, vacation, etc.)* and if we consumers didn't actively choose a new FI, then one would be "chosen" for us. With successful advocacy, we were able to secure an "extension" of the transition for a few more weeks, but many of us lost PAs in the transition.

12. A fellow Nursing Home Transition & Diversion Waiver participant friend of mine in Far Rockaway, Queens NY had 5 PAs and only 2 of them followed her to the new FI. Another friend of mine, who has cerebral palsy and is in the OPWDD (developmental disabilities) Waiver, lost longtime PAs who had understood her well through her speech impediment after working with her for many years. It was a very traumatic, confusing and tumultuous time – and it even pains me to revisit it for this very declaration. Many of us couldn't get out of bed, brush our teeth, eat meals after the transition and quite frankly, with the home care shortage even worse **now** than in 2017, the transition to a single statewide FI would be even **more** devastating.

13. In the fee-for-service delivery system, there are no "networks," let alone "out of network benefits" for a provider that is not contracted with the local county of social services. Fee-for-service, after all, is not "managed care," so we consumers didn't even have "continuity of care" or "transitional care" protections afforded to us, like our "managed care" brothers and sisters. But I felt that perhaps there was some way to prevent this from happening, and so I contacted the NYS OTDA Fair Hearing office before the transition was set to be scheduled. I received a written response that said, "*a fair hearing cannot be scheduled, as you requested, since this is not a hearable issue within the purview of the administrative hearing process*", concluding that I may wish "*to seek other legal counsel to review what remedies under the law are available to you*".

14. It is in that spirit, that I write this declaration, and from the open wound of that time. I currently have one PA who followed me over in the transition from Concepts of Independence to the Chinese-American Planning Council, and I know that our working relationship **cannot** withstand yet another transition. In short, I will personally lose at least one PA, if not all three.

15. It is not true that "an FI is an FI is an FI." Each FI has its own way of working with consumers in CDPAP and in the ***immensely*** complex, often bureaucratic, byzantine labyrinth of the NYS Medicaid program, they are often our only connection. Each FI has its own culture. I remember the Consumer Advisory Committee meetings at Concepts fondly; always passionate, collaborative, feisty and joyful and informative! My current FI, Chinese-American Planning Council and its Director of Patient Services has been so very kind and accommodating– I let them know this in the annual satisfaction surveys that we fill out.

16. The world has changed since COVID and we should learn from that. During the height of the pandemic, I received weekly phone calls from a nurse at my FI, just checking in to ask how I'm feeling and to make sure I had everything I needed. This was of course, above and beyond what is required of an FI, but it was the human touch that respected how vulnerable we can all be, and how important it is to have your FI, essentially your ***liaison*** to the larger NYS Medicaid home care system, be just one quick phone call away.

17. Like Judy Heumann, the late disability activist once said: "*Disability only becomes a tragedy when society fails to provide the things we need to lead our lives."*

18. Lastly, I want to emphasize that in CDPAP, we consumers all have various individualized needs, and very personalized care. In CDPAP, choosing our FI ("supports") and choosing our PAs ("services," if you will) are **vital** to not only the way we navigate this world, but also the way in which we ***take care*** of our own ***care***. It just simply comes down to dignity.

Executed on August 25, 2024.

Trina-Rose Cutugno

EXHIBIT 6

DEKLARASYON YVONNE FRANCOIS

1. Mwen rele Yvonne Francois. Mwen gen 73 lane, epi m konpetan pou m fè Deklarasyon sa a. Mwen gen konesans pèsonèl sou zafè ki presize nan Deklarasyon sa a.

2. Mwen fèt ann Ayiti epi m pale Kreyòl sitou. Kounye a, mwen abite nan Long Island, epi m resevwa swen lakay mwen dapre Pwogram New York Èd Swen Pèsonèl Konsomatè Dirije (Consumer Directed Personal Assistance Program, "CDPAP") pou ede m jere pwoblèm nan jenou ak nan do, vètij, epi konplikasyon akòz opresyon.

3. Yo te jwenn mwen kalifye pou m resevwa sèvis CDPAP paske m kalifye tou pou asistans medikal anpasan pa Medicaid epi m kalifye pou swen dire long oswa swen pèsonèl.

4. Pwofesyonèl medikal ak pwofesyonèl tretman yo nan Eta New York te detèmine sèvis nan kay ak nan kominote apwopriye pou mwen, epi mwen anfavè sèvis sa yo. Jiskaprezan, Eta a te pran anchaj sèvis nan kay mwen yo yon fason rezonab.

5. Mwen te travay avèk Safe Haven Home Care kòm entèmedyè fiskal mwen ("FI") pandan apeprè senk ane.

6. Mwen te dekouvri Safe Haven pou premye fwa nan yon moman kote m te fristre epi m pa te satisfè avèk ajans swen nan kay ki t ap ban m èd la. Ajans sa a te voye anpil èd diferan epi m te santi èd sa yo pa te gen konpasyon, yo pa te ede m, epi yo te distrè nan televizyon ak nan voye tèks lè y ap bay swen yo. Mwen te rankontre yon moun ki t ap resevwa sèvis CDPAP e ki t ap travay avèk Safe Haven, epi lè m te di l pwoblèm m genyen avèk ajans swen lakay la, li te rekòmande pou m kontakte Safe Haven.

7. Lefèt ke m jwenn Safe Haven te chanje lavi m epi m kwè, sa te sove lavi m. Non sèlman Safe Haven ede m ak tout dokiman ki asosye avèk aktivite pou anplwaye èd pèsonèl (Personal Assistant, "PA") mwen an, men tou PDG ak anplwaye li yo sousye toutbon pou mwen

ak pou sante e byennèt mwen, epi yo asire mwen resevwa sèvis mwen bezwen yo. Mwen pa konnen kisa mwen ta fè san Safe Haven.

8. Neve m sèvi kòm èd pèsonèl mwen. Li ede m sèt jou sou sèt ant 7:00 am ak 1:00 pm. pou travay toulejou yo tankou lesiv ak netwayaj, epi li akonpaye m nan randevou mwen genyen souvan kay doktè. Pafwa mwen gen senk randevou nan yon semèn.

9. Lè mwen te chwazi Safe Haven kòm FI mwen, neve m te ale nan biwo Safe Haven lan pou ranpli dokiman ki nesesè yo, epi li te rankontre tou avèk PDG a, Rouandy Pascal, pou chita pale sou responsablite li antanke PA mwen. Madame Pascal trè janti epi li gen konpasyon, men li se pwofesyonèl e li te trè serye nan revizyon obligasyon CDPAP yo. Li te ensiste sou lefèt ke menm si neve m se fanmi m, li dwe prezante nan lè egzijib yo pou l travay epi ede m.

10. Sepandan, neve m pa janm gen pwoblèm pou l travay di ak pou l pran swen m chak jou. Mwen te jwenn manm fanmi yo bay pi bon swen ak pi bon kalite swen pase èd pou swen lakay yo mete yo.

11. Apeprè menm epòk lè m te kòmanse resevwa sèvis CDPAP yo, Madame Pascal te vin lakay mwen epi li te eksplike kijan CDPAP fonksyone, li te repase sèvis neve m lan dwe ban m, epi li te aprann mwen plis bagay toujou sou Safe Haven ak wòl li.

12. Mwen ka toujou konte sou Safe Haven pou ede m ak sa m bezwen epi ede m pran responsablite m nan pwogram nan. Anplwaye Safe Haven yo gen sousi vrèman pou moun epi yo depase tèt yo pou pran swen m. Se sa konsomatè CDPAP yo bezwen e se sa yo merite, e se poutèt sa ajans lan byen rele Safe Haven — yo vrèman pwoteje tout moun y ap sèvi.

13. Mwen kwè yon sèl FI pral iyore mwenmenm e lòt konsomatè CDPAP yo epi konsantre pito sou lajan ak pwofi.

14. Mwen apresye endepandans ki akonpaye viv lakay la; mwen apresye dèske m resevwa swen nan men yon PA mwen te vin abitye ak li, epi m gen yon atachman solid ak li; epi m apresye relasyon m avèk Safe Haven ak anplwaye li yo ke m fè konfyans pou kowòdone eleman swen mwen yo; sinon mwen pa t ap kapab kowòdone yo, epi mwen apresye dèske yo montre yon sousi reyèl anvè mwen. Bagay sa yo te gen enpak pozitif sou sante m ak lavi toulejou m.

15. Antanke konsomatè CDPAP, li enpòtan pou m chwazi yon FI ki ede m reponn ak responsablite mwen yo. Si m te gen lechwa, mwen t ap kontinye resevwa sèvis CDPAP yo lakay mwen, ke Safe Haven ak neve m lan bay.

16. Mwen te egzamine e apwouve tèks tradiksyon sètifye Deklarasyon an kreyòl sa a anvan mwen siyen ni vèsyon Kreyòl ni vèsyon Anglè Deklarasyon an.

Avèk posiblite sanksyon pou fo temwayaj, mwen deklare sa ki endike anwo la a vre e kòrèk. Siyen nan dat 7/15, 2024.

Yvonne Francois

DECLARATION OF YVONNE FRANCOIS

1. My name is Yvonne Francois. I am 73 years old, and I am competent to make this Declaration. I have personal knowledge of the matters set forth in this Declaration.

2. I was born in Haiti and speak primarily Creole. I now live in Long Island, and I receive care in my home under New York's Consumer Directed Personal Assistance Program ("CDPAP") to help me manage knee and back problems, vertigo, and complications due to asthma.

3. I was deemed eligible to receive CDPAP services because I am also eligible for medical assistance through Medicaid and eligible for long term care or personal care.

4. Medical and treatment professionals in New York State have determined that home- and community-based services are appropriate for me, and I favor such services. Thus far, the State has reasonably accommodated my home-based services.

5. I have worked with Safe Haven Home Care as my fiscal intermediary ("FI") for approximately five years.

6. I first learned of Safe Haven at a time when I was frustrated and dissatisfied with the home care agency that was providing me with assistance. That agency sent many different aides who I felt were not compassionate, did not help me, and were distracted from their caregiving by TV and texting. I met someone who was receiving CDPAP services and working with Safe Haven, and, when I told her about my problems with the home care agency, she recommended that I contact Safe Haven.

7. Finding Safe Haven changed my life and, I believe, saved my life. Safe Haven not only helps me with all the paperwork associated with employing my personal assistant

("PA"), but also its CEO and employees care deeply about me and my health and well-being and make sure I am receiving the services I need. I don't know what I would do without Safe Haven.

8. My nephew serves as my personal assistant. He helps me seven days a week from 7:00 am to 1:00 pm. with everyday tasks such as laundry and cleaning, and he accompanies me to my frequent doctor's appointments. Sometimes I have five appointments in a week.

9. When I selected Safe Haven as my FI, my nephew went to Safe Haven's offices to fill out the required paperwork, and he also met with the CEO, Rouandy Pascal, to discuss his responsibilities as my PA. Madame Pascal is very kind and compassionate, but she is professional and was all business when reviewing CDPAP obligations. She emphasized that even though my nephew is family, he needs to show up at the required hours to work and assist me.

10. However, my nephew has never had a problem with working hard and taking care of me every day. I have found that family members provide better care and quality than assigned home care aides.

11. Around the same time when I began receiving CDPAP services, Madame Pascal came to my house and explained how CDPAP works, reviewed what services my nephew needed to provide for me, and taught me more about Safe Haven and its role.

12. I can always count on Safe Haven to assist with what I need and to help me carry out my responsibilities under the program. Safe Haven employees genuinely care about people and go above and beyond to take care of me. This is what CDPAP consumers need and deserve, and this is why the agency is fittingly called Safe Haven—they truly protect everyone they serve.

13. I believe that a single FI will ignore me and other CDPAP consumers and focus on money and profits instead.

14. I value the independence that comes with living at home; I value receiving care from the PA to whom I have become accustomed and with whom I have a strong bond; and I value my relationship with Safe Haven and its employees whom I trust to coordinate the elements of my care that I would be unable to otherwise and to show genuine concern and care for me. These things have had positive impacts on my health and my daily life.

15. As a CDPAP consumer, it is important to me to choose the FI that helps me carry out my responsibilities. If I had my choice, I would continue to receive CDPAP services in my home, provided by Safe Haven and my nephew.

16. I reviewed and approved the text of the certified Creole translation of this Declaration before signing both the Creole and English versions of the Declaration.

I declare under penalty of perjury that the foregoing is true and correct. Executed on 7/15, 2024.

Yvonne Francois

CERTIFICATE OF TRANSLATION

I, Patrick Paul, am fluent in the Creole and English languages. I have been translating documents for 20 years and am competent to translate documents from English into Creole. I hereby certify that the document identified below that was translated from English into Creole, and is true and accurate, to the best of my knowledge and belief.

Reference:
CDPAP 365-f challenge - V. Jeannot declaration draft 6-26
CDPAP 365-f challenge - Y. Francois declaration draft 6-26

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Signature

Patrick PAUL

Name

July 05, 2024

Date

Employer: Independent Contractor / Hired by TransPerfect Translations, Inc.

Employer Address: 1250 Broadway, 7th Floor, New York, NY 10001

Phone Number: 646.357.3196

EXHIBIT 7

Carol Gittens #YU32485S

To Whom it may concern:

This letter is to formally state that I Carol Gittens have entrusted Sundance Home Care as my vendor for home care and personal assistance needs since February 1, 2020. I have been experiencing a significant mental and physical decline and as such I heavily rely on the comprehensive services provided by my trust agency Sundance Home Care.

Sundance Home Care has been instrumental in delivering consistent and reliable care that I require. They have assigned me a dedicated caregiver who understands my person centered care needs; providing compassionate, personalized care. This continuity of care is crucial for my well-being, ensuring that I receive the attention and support necessary to manage my declining condition.

Additionally, Sundance Home Care assists me with my insurance-related inquiries, ensuring that all necessary documentation and claims are processed efficiently. This support alleviates a significant burden for me, allowing me to focus on my health and well-being.

The care team at Sundance Home Care is dedicated to providing person-centered care, treating me with the respect and dignity I deserve. The team at Sundance have become like an extended family, offering not only medical and personal care but also emotional support and companionship.

It is imperative that I continue to receive care from Sundance Home Care, as any changes to my current care arrangement would significantly impact my quality of life. The trust and reliance I place in Sundance Home Care is crucial for my continued well-being.

I declare under penalty of perjury that the foregoing is true and correct. Executed on 7/9/24.

Sincerely,

Carol Gittens

EXHIBIT 8

Zilla Cummings #PE79082D

I am writing to formally state that I Zilla Cummings rely on Sundance Home Care as my primary care provider for my home care needs. I have entrusted them with my care since 12/1/22. I am currently experiencing cognitive decline and require consistent and reliable care, which Sundance Home Care has been providing.

Sundance Home Care has proven to be an agency that I trust wholeheartedly. The agency has been instrumental in providing me with a trusted caregiver who understands my specific needs and offers compassionate and professional care. Additionally, Sundance Home Care has been responsible for managing my insurance-related inquiries, ensuring that all necessary paperwork and claims are handled efficiently and accurately.

The care provided by Sundance Home Care is centered on my personal needs and preferences, reflecting their commitment to person-centered care. The team at Sundance treats me like family, offering me not only medical and personal care but also emotional support and companionship.

It is my hope that this letter will underscore the critical role that Sundance Home Care plays in my daily life and the trust and reliance she places in their services.

I declare under penalty of perjury that the foregoing is true and correct. Executed on 7/10/24.

Sincerely,

Zilla Cummings

EXHIBIT 9

Elizabeth Dunrod #PJ27730Z

To Whom it may concern:

I am writing to advocate on behalf of myself Elizabeth Dunrod, who relies on Sundance Home Care as my trusted care provider since 12/1/23. It is imperative that I continue to receive care from Sundance Home Care, as any changes to my current care arrangement would significantly impact my quality of life.

I have established a strong and trusting relationship with the caregivers and staff at Sundance Home Care. The consistency and quality of care I receive from Sundance Home Care are vital to my well-being. The caregivers understand my specific needs, preferences, and routines, ensuring that I receive personalized and compassionate care.

As a cancer survivor I put the utmost importance on my health care providers. Changing my care provider would not only interfere with my daily life but also pose potential risks to my health and emotional stability. My choice of Sundance Home Care as my care provider is a testament to the high-quality services they offer.

I urge you to consider the profound impact that any changes to my care provider would have on me. Allowing me to continue with Sundance Home Care is crucial for preserving my quality of life and ensuring my continued well-being.

I Declare under penalty of perjury the foregoing is true and correct. Executed on 7/9/24

Sincerely,

Elizabeth Dunrod

EXHIBIT 10

Я обслуживаюсь в агентстве Vivid Care с начала 2023 года по программе CDPAP. Персонал этой компании всегда оказывает мне помощь и поддержку по любому поводу, за что я безмерно благодарен. Вежливость, профессионализм, и образцовое обслуживание- это все характеристики этого агентства.

Vivid Care помогает мне решить все вопросы по медикейту, когда наступает время ре-сертификации. Координатор всегда участвует если необходимо решить вопросы со страховой компанией, медицинскими принадлежностями, или транспортом.

Я бы не хотел менять эту программу так как она дает мне возможность получать помощь от моего родственника, а не от чужого мне человека, а ему, возможность получать за это зарплату.

Я заявляю под страхом наказания за лжесвидетельство, что вышеизложенное верно и правильно.

Подпись

11 июля_2024 года

ЕВГЕНИЙ КАРАСЮНОК (EUGENE KARASYUNOK)

I have used the services of the Vivid Care agency since the beginning of 2023 under the CDPAP program. The staff of this company have always given me help and support with everything, which I am extremely grateful for. Politeness, professionalism and exemplary service: these are all characteristics of this agency.

Vivid Care helps me resolve all Medicaid issues when it is time for recertification. The coordinator is always involved if I need to resolve issues with the insurance company, medical supplies or transport.

I would not like to leave this program because it makes it possible for me to get help from a family member rather than a stranger, and he can be paid a salary for it.

I declare under penalty of perjury that the foregoing is true and correct.

[signature] July 11, 2024
Signature

EUGENE KARASYUNOK [bilingual text]

CERTIFICATE OF TRANSLATION

I, Anna Wilson, am fluent in the Russian and English languages. I have been translating documents for over 40 years and am competent to translate documents from Russian into English. I hereby certify that the document identified below was translated from Russian into English, and is true and accurate to the best of my knowledge and belief.

Reference: Declaration -Russian Patient E- E Karasyunok - signed

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Linguist Signature

Anna Wilson

Linguist Name - Printed

07/24/2024

Date

Employer: Independent Contractor / Hired by TransPerfect Translations, Inc.

Employer Address: 1250 Broadway, 7th Floor, New York, NY 10001

Phone Number: 1-212-689-5555

EXHIBIT 11

To whom it may concern:

My name is Gavrilov Nikolay, my daughter is my personal assistant who had to put her work and life on hold to take care of me. I speak Russian and an active member of my community.

My health was deteriorating with my age, and I developed multiple health conditions. Once I was not able to take care of myself. My doctor recommended home care services. I needed medication reminders, meal preparations, laundry, cleaning, grocery shopping, I needed assistance going to the doctor. I was embarrassed and afraid to ask strangers for help or any assistance. My daughter assisted me with home care agency search. We had called many different agencies, each of them where able to provide information on different types of services, caregivers wages and their benefits. Some were friendly, some were not, somewhere knowledgeable but forgetting to call us back, some were just putting us on long holds on a phone, some agencies were too far away from us or did not speak Russian. During those calls one thing I learned that my daughter could take care of me and get paid.

Since I could chose my daughter to be my caretake, and previous experience we started to look for the agency that is closest to my home, the agency who can provide best care for me and of cause better pay and benefits for my daughter. Agency who can understand my culture and speak my language, agency that I can trust my care and I can speak to representative in-person if I need too.

International home care turned out to be the best fit for me and my caretaker. International Home Care team was very knowledgeable (I was educated on different types of services), attentive and patient with me, able to explain everything in a language that I could understand during enrollment process and assist my daughter with registration process.

My CDPAP services begin in December of 2018 with International Home Care Services of NY and we would like to remain with international Home Care as long as I need to.

I'm grateful to this program, I'm grateful that I had a chance to speak to other agencies and learn many things and I'm grateful for the choice to choose International Home Care services for my services. Who can speak Russian with me with out any interpreters

At International Home Care I have designated Care Coordinator, who is always available to answer my question in Russian, and able to understand my needs. International home care always goes the extra mile for me. I remember asking them for assistance when I received papers from the Medicaid office, they were able to assist me in person. I had a question about food stamps, and they were able to answer. During COVID-19 my coordinator frequently calls me and my PA to make sure we are ok, and we are taking all the necessary

precautions. During flu season agency check if I got a flu shot or if need assistance to get one.

During winter storms, My coordinator calls to make sure I stay indoors and make sure that my daughter able to come to work or hot weather on a summer my coordinator always calls to make sure my AC is working, I have water, food and medication in the house, recommend staying indoor during peak of the hit. I know sometimes a get annoyed by those calls but at the end of the day I know my agency cares for my wellbeing. Also, my coordinator calls me on a monthly basis to check if I have been in a hospital or had any falls or if I need physical therapy at home or if I have seen my doctor recently or if take my medications, or if I'm happy with my daughter's services. It a lot of calls and questions, but I don't mind, in a way it makes me feel that I'm being cared for. Sometimes, during those calls we talk about history or movies or how things were when we all were back in the USSR. I'm glad to have Coordinator who speaks Russian without interpreters and have same cultural background. When insurance company calls It is very difficult and tiring for me to communicate with interpreters on a phone because often, they don't translate correctly, sometime connection is bad and phone calls are very longer and frustrating, I had to repeat myself few times.

My daughter works for me 40 hours per week, I'm her full-time job unfortunately. I'm glad she compensated for her job fairly, it makes feel less of a burden to her. I'm terrified of the idea that my daughter wont be able to continue to be my caregiver and even worthed have s a stranger in a home.

Furthermore, no one can replace my daughter cause no one knows my health, my needs more then my daughter. I don't think I can trust my care to anyone else.

I'm grateful to be with International Home care services of NY. I do not wish to be with any other agency. And I hope that I won't ever be forced to get services somewhere else.

I declare under penalty of perjury that the foregoing is true and correct.

Nikolay Gavrilov.

8/16/2024

EXHIBIT 12

DECLARATION OF ANNA ROZENBOYM

1. My name is Anna Rozenboym, I am over the age of 18 years, and I am competent to make this Declaration. I have personal knowledge of the matters set forth in this Declaration.

2. My parents, Vitaliy Rozenboym and Margarita Rozenboym, are Holocaust survivors who immigrated to the United States from Russia in 1994.

3. My father is now 86 years old, and my mother is 84. Because of their age and health conditions, they receive in-home care under New York's Consumer Directed Personal Assistance Program ("CDPAP"). They are considered a "mutual case" under CDPAP, as two individuals receiving care in the same household.

4. I serve as a personal assistant ("PA") for my parents. They also have two other PAs, and together we provide my mother with 49 hours of care weekly and my father with 56 hours weekly.

5. My mother has Parkinson's disease and is legally blind in both eyes. My father has multiple conditions including cerebral thrombosis and pulmonary embolism, autoimmune disease, kidney stones, and cerebral amyloid angiopathy.

6. As a PA, I assist them with just about everything they need at home for everyday living, from cooking, cleaning, and other daily chores to helping them in the bathroom and with bathing. I also accompany them to their doctors' offices and physical therapy appointments and help them get outside.

7. When my parents began receiving CDPAP services, we chose Silver Lining Homecare Agency, Inc. to be their fiscal intermediary ("FI"). I knew Jacob Joffe, Silver Lining's Administrator, because his parents are also Holocaust survivors like mine. We live in the same community as Jacob, and we have a similar culture and understanding given our

background. We also knew Silver Lining's office was close by, and that proximity was a big factor in choosing them. They could also meet the language needs of my parents, who speak Russian.

8. Silver Lining helped us set up services for my parents and provided me with orientation as a PA. Jacob has been to my parents' home and was personally involved in helping them set up their CDPAP services, and he is also knowledgeable about other services they receive as Holocaust survivors.

9. Since that time, Silver Lining has been meeting our needs, providing excellent service, and making sure my parents receive the care they need. My parents and I are in constant and direct communication with several employees at Silver Lining, and the ease of communication is one of Silver Lining's greatest assets. I can call the agency and know I won't have to wait on hold. Someone always picks up the phone and responds to emails and text messages very quickly.

10. Another great asset is the relationships we have built with Jacob and Silver Lining's employees. My parents and I have established a comfort level with Silver Lining. This comfort, stability, and continuity is important for them, particularly as elderly people who are not English speakers and have issues with memory and anxiety. They need to know that there is a specific person whom they can contact who speaks their language, and they want to be able to communicate with the same people over the years as much as possible. Silver Lining has provided that stability for my parents and me.

11. A single statewide FI could not provide the same level of service that Silver Lining has, and it could not replicate the relationship my parents and I have with the employees at Silver Lining. This would be detrimental to my parents and their health care services.

12. For example, my parents would be very uncomfortable talking to someone on the phone whom they did not know. The single FI plan would add to their stress and anxiety, and it would contribute to a loss of community.

13. A testament to our satisfaction with Silver Lining, my parents have told their friends and our family members to also reach out to Jacob, and those individuals have chosen to work with Silver Lining as well. My parents would prefer to continue using Silver Lining as their FI, and they need that continuity to promote their health and in-home care.

I declare under penalty of perjury that the foregoing is true and correct. Executed on 7/25/2024, 2024.

Anna Rozenboym

EXHIBIT 13

DECLARACIÓN DE ANA TAVAREZ DE ACOSTA

1. Mi nombre es Ana Tavarez de Acosta. Soy mayor de 18 años y soy competente para formular esta Declaración. Tengo conocimiento personal de los asuntos que se expresan en esta Declaración.

2. Me desempeño como asistente personal o AP (personal assistant, "PA") para mi madrina, Patria Reynoso, que recibe atención en su hogar en virtud del Programa de Asistencia Personal Dirigida por el Consumidor (Consumer Directed Personal Assistance Program, "CDPAP") de Nueva York.

3. Patria tiene demencia y requiere una "jornada intensiva dividida" de atención durante el día y la noche. Debido a su afección médica, está prácticamente en la cama, aunque puede pasar a una silla de ruedas con ayuda.

4. Ayudo a Patria durante la noche con tareas que incluyen darla vuelta en la cama cada hora para evitar que aparezcan llagas por estar tanto en la cama, cambiarle sus pañales para adultos, darle masajes, hacer que practique algunos ejercicios y bañarla, de ser necesario.

5. Patria tiene otra AP durante la noche y otras dos durante el día. Las AP que trabajan de día también ayudan con tareas tales como ducharla, prepararle la comida, limpiar la casa, lavar la ropa y otras tareas.

6. La representante designada de Patria es su hermana, Luz Fernández.

7. He trabajado como AP de Patria durante aproximadamente cuatro años. Durante ese lapso, House Calls Home Care ha sido la institución intermediaria fiscal o IF ("Fiscal intermediary, FI") que se asegura de que Patria reciba los servicios del CDPAP y se encarga de mi empleo y nómina.

8. Patria y Luz eligieron House Calls Home Care como la institución IF de Patria debido a su presencia local en Washington Heights, a solo un par de cuadras de nuestras casas. Cuando entré por primera vez a la oficina de House Calls, el personal me trató muy bien. También hablaban español, algo que fue fundamental para establecer los servicios porque no hablo inglés.

9. Puedo entrar a la oficina de House Calls en cualquier momento, y el personal y yo nos entendemos en español. Concurro a su oficina en caso de tener preguntas relacionadas con la comprensión de mi horario, cheques de pago y vacaciones, y ellos organizan programas de capacitación que me ayudan a cuidar mejor a Patria y cumplir con mis responsabilidades. House Calls siempre trata mis inquietudes y me ayuda.

10. Todos los asistentes de Patria están en comunicación regular, y las AP que trabajan de día me han informado que los empleados de House Calls también se comunican con Patria y con las AP que están en la casa de Patria cada tanto.

11. Tendría problemas si tuviera que plantear mis inquietudes en un portal en línea o en un centro de atención telefónica con una única institución IF distante para todo el estado en lugar de simplemente caminar hasta la oficina de House Calls. No soy experta en el uso de la tecnología y no me sentiría cómoda manejando las cosas de manera remota.

12. Mi acceso a House Calls y a los servicios de IF que brindan promueven el bienestar de Patria.

13. Sin House Calls, sin su presencia en el lugar y su ayuda inmediata, en español, creo que la atención de Patria se vería comprometida y perdería a sus AP.

14. Conozco a Patria desde que era una niñita. Ahora ha perdido casi toda la memoria y le preocupa quién está en su casa. Entiendo que, en ocasiones, cuando hay

cuidadores sustitutos, Patria está triste y agitada, y no quiere comer ni levantarse de la cama. Sin embargo, existe una relación de confianza entre Patria y sus AP, y las otras AP y yo podemos mantenerla tranquila y en paz.

15. Patria sufriría un gran daño si House Calls fuera obligada a cerrar y si ella se viera obligada a hacer la transición a una institución IF estatal. Creo que Patria se vería obligada a recibir atención en un asilo de ancianos.

16. He revisado y aprobado el texto de la traducción certificada en español de esta Declaración antes de firmar tanto las versiones en español como en inglés de la Declaración.

Declaro, bajo pena de perjurio, que lo que antecede es fiel y veraz.

Firmado el 10 de Julio de 2024.

Ana Tavarez de Acosta

DECLARATION OF ANA TAVAREZ DE ACOSTA

1. My name is Ana Tavarez de Acosta, I am over the age of 18 years, and I am competent to make this Declaration. I have personal knowledge of the matters set forth in this Declaration.

2. I serve as a personal assistant ("PA") for my godmother, Patria Reynoso, who receives care in her home under New York's Consumer Directed Personal Assistance Program ("CDPAP").

3. Patria has dementia and requires a "split shift" of round-the-clock care during the day and overnight. Because of her medical condition, she is mostly in bed, though she can transfer to a wheelchair with assistance.

4. I assist Patria at night-time with tasks that include repositioning her in bed every hour to prevent bed sores, changing adult diapers, providing massages and some exercises, and bathing her if needed.

5. Patria has one other PA during the night and two others during the day. The daytime PAs also help with showering, preparing meals, cleaning the home, washing clothes, and other tasks.

6. Patria's designated representative is her sister, Luz Fernandez.

7. I have worked as Patria's PA for approximately four years. During that time, House Calls Home Care has been the fiscal intermediary ("FI") that makes sure Patria receives CDPAP services and handles my employment and payroll.

8. Patria and Luz chose House Calls Home Care as Patria's FI because of its local presence in Washington Heights, just a couple of blocks away from our homes. When I first

went into the House Calls office, the staff treated me very nicely. They also spoke Spanish, which was essential to setting up services because I do not speak English.

9. I can walk into the House Calls office at any given point, and the staff and I understand each other in Spanish. I go to their office for questions related to understanding my time, paychecks, and vacation, and they host training programs that help me better care for Patria and fulfill my responsibilities. House Calls always promptly addresses my questions and helps me.

10. All of Patria's aides are in regular communication, and the daytime PAs have informed me that House Calls employees also check in on Patria and the PAs at Patria's house from time to time.

11. I would have trouble if I had to pose my questions to an online portal or call center with a distant, single statewide FI rather than walking into House Calls' office. I am not tech savvy and would not feel comfortable handling things remotely.

12. My access to House Calls and the FI services they provide promotes Patria's well-being.

13. Without House Calls and its on-the-ground presence and immediate help, in Spanish, I believe Patria's care would be compromised and she would lose her PAs.

14. I have known Patria since I was a little girl. She has now lost most of her memory and is concerned about who is in her home. I understand that on occasions when substitute caregivers are there, Patria is sad and agitated and does not want to eat or get out of bed. There is a trusting relationship between Patria and her PAs, though, and the other PAs and I are able to keep her calm and at peace.

15. Patria would suffer great harm if House Calls were forced to close and she were forced to transition to a statewide FI. I believe Patria would be forced into nursing home care.

16. I reviewed and approved the text of the certified Spanish translation of this Declaration before signing both the Spanish and English versions of the Declaration.

I declare under penalty of perjury that the foregoing is true and correct. Executed on July 10th, 2024.

Ana Tavarez de Acosta

CERTIFICATE OF TRANSLATION

I, Karina Fabri i, am fluent in the Spanish and English languages. I have been translating documents for 32 years and am competent to translate documents from English into Spanish. I hereby certify that the document identified below that was translated from English into Spanish, is true and accurate, to the best of my knowledge and belief.

Reference:
CDPAP 365-f challenge - A. Ta are draft declaration 6-26

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Firmado digitalmente por FABRIZZI Maria Karina
Fecha: 2024.07.04 11:53:48 -03'00'

_____
Signature

Karina Fabri i
_____
Name

July 4, 2024
_____
Date

Employer: Independent Contractor / Hired by TransPerfect Translations, Inc.

Employer Address: 1250 Broadway, 7th Floor, New York, NY 10001

Phone Number: 646.357.3196

EXHIBIT 14

Regarding Pedro Peralta and Easy Choice Agency:

To whom it may concern;

I decided to enroll my uncle in Easy Choice Agency as I had been struggling to obtain services that met our needs. My family is from the Dominican Republic; thus, English is not our first language. My uncle Pedro relies on me for all his needs. The idea of navigating services in the community for my uncle was very challenging. We encountered different individuals in my attempts to obtain services that his doctor stated he needed following a history of liver transplant and a long list of medical conditions.

Easy Choice was the first agency that treated me and my family with respect. Not only did the agency assist me with understanding the services for which my uncle qualified, but they also showed genuine care and empathy. As a consumer, my uncle always expressed interest in having me do his care, as I already managed everything else in his life. He exercised his option for consumer-direct care.

Easy Choice is an agency that understands our culture, our needs, but most importantly, it is accessible to us and provides assistance on issues that surface immediately. The agency has assisted my uncle in maintaining his benefits actively, educated me on ways to secure resources for my uncle, and whenever I'm in need of anything, I can call them, and they are reliable. When we began working with Easy Choice, my uncle did not have access to his own apartment and was forced to rent a room. With the assistance of Easy Choice Agency, my uncle now enjoys his own apartment and has been able to connect with community resources that have kept him away from unplanned hospitalizations.

Navigating medical needs, mental health needs, housing needs, social needs, and financial needs was a mountain to climb, but we have managed thanks to Easy Choice Agency. When my uncle was informed about the possibility of losing this agency, he did not get out of bed for almost a week as he feared that his stability would be lost if he lost the assistance that this agency provides. Easy Choice is a small agency where my uncle is greeted by his name from the receptionist to the coordinators. His services are at his disposal and, most importantly, are offered by people he has learned to trust.

In the past, my uncle was a victim of identity theft and financial exploitation. He now understands ways to avoid these scammers by working closely and only with Easy Choice Agency. I will be unable to list all the personal services my uncle receives from this agency, but I can't imagine what we would do if this agency were no longer able to provide access and service to my uncle. My uncle remains in such fear of losing Easy Choice that he has

mentioned it to his doctor. In our last appointment, I had to explain what he was referring to as the doctor was confused.

I hope this agency can continue to provide outstanding and individual services to my uncle but overall, to our community. The loss of Easy Choice will impact not just my uncle and my family, but many others.

I declare under penalty of perjury that the foregoing is true and correct. Executed on August 20, 2024.

Francis Paulino

francispaulino639@gmail.com

929-278-0081

Re: Pedro Peralta

EXHIBIT 15

Наша мама обслуживается в агентстве Vivid Care с 2017 года по программе CDPAP. В первую очередь, мы бы хотели выразить искреннюю благодарность за исключительную поддержку, отзывчивость и заботу, которую мы получаем в течении всех этих лет от персонала компании.

Хотя программа CDPAP это одновременно возможность ухаживать за мамой, получать заработную плату, но это также и вызов для всей семьи: мама становится нашим работодателем, и мы обязаны своевременно и точно выполнять план ухода, указанный медсестрой MLTC. Мама не хочет менять эту программу, т. к. считает что семья может удовлетворить ее нужды лучше, чем посторонний человек.

Мы не хотим менять это агентство. Здесь всегда находят быстрое решение всех вопросов. Сотрудники внимательны к деталям. Мы никогда не слышали слово «нет» по отношению к нам. Вежливость, профессионализм, и образцовое обслуживание- это все характеристики этого агентства.

Vivid Care помогает решить все вопросы по медикейту, когда наступает время ре сертификации. Координатор всегда участвует если необходимо решить вопросы со страховой компанией, медицинскими принадлежностями, или транспортом.

Наша мама довольна. Она чувствует что окружена командой профессионалов. Мы в свою очередь, являясь работниками Vivid Care, получаем своевременную зарплату, отпускные, больничные.

Хочется подчеркнуть исполнительность, открытость, аккуратность и доброжелательность Vivid Care как работодателя.

Our mother has been receiving care from the Vivid Care agency since 2017 through the CDPAP program. First of all, we would like to sincerely thank company personnel for the exceptional support, empathy and care that we have been experiencing over the years.

Although the CDPAP program is an opportunity to take care of mom and receive a salary, it is also a challenge for the whole family: mom has become our employer, and

we are required to implement the care plan specified by the MLTC nurse in a timely and accurate manner. Mom does not want to change this program, as she believes that the family can cater for her needs better than a stranger.

We do not want to change this agency. They always find quick solutions to our issues. Staff always have great attention to detail. We have never heard the word “no” towards us. Courtesy, professionalism, and excellent service are all hallmarks of this agency.

Vivid Care helps with all questions about Medicare when it comes to re-certification. The coordinator is always available to help if there are any issues with the insurance company, medical supplies, or transportation.

Our mom is happy. She feels that she is surrounded by the team of professionals. In turn, as employees of Vivid Care, we receive timely salaries, vacation pay, and sick leave benefits.

I would like to highlight dedication, openness, attention to detail, and friendliness that Vivid Care demonstrates as an employer.

I declare, under penalty of perjury, that the information provided is true and accurate.

[signature] July 8, 2024

Signature

Tatyana Kotsyuba

TRANSPERFECT

City of New York, State of New York, County of New York

I, Jacqueline Yorke, hereby certify that the document "Vivid Care - Russian declaration 7-8-24" is, to the best of my knowledge and belief, a true and accurate translation from English into Russian.

Jacqueline Yorke

Sworn to before me this
July 15, 2024

Signature, Notary Public

WENDY POON
Notary Public - State of New York
No. 01PO0000184
Qualified in Queens County
My Commission Expires February 02, 2027

Stamp, Notary Public

EXHIBIT 16

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

VIOLETTE JEANNOT, YVONNE FRANCOIS, ANTONINA FRIMER, EUGENE KARASYUNOK, NELLI KOTSYUBA, PEDRO PERALTA, VITALIY ROZENBOYM, MARGARITA ROZENBOYM, CESAR RIOFRIO, MUHAMMAD O. ISLAM, TRINA-ROSE CUTUGNO, CAROL GITTENS, ELIZABETH DUNROD, ZILLA CUMMINGS, CHARLOTTE DEWITT, RASHIDA SMITH, NIKOLAY GAVRILOV, NAUM GALLER, AASHA SERVICES, INC., BANGLA CDPAP SERVICES INC., BEST HELP HOME CARE CORP., CAREAIDE DIRECT, INC., CAREFIRST CDPAP, CORP., CELESTIAL CARE INC., EASY CHOICE AGENCY, INC., ELIM HOME CARE AGENCY LLC, ENRICHED HOME CARE AGENCY INC., HEALTHY LIFE CHOICE, INC., HOME CHOICE LLC, THE DORAL INVESTORS GROUP, LLC, DBA HOUSE CALLS HOMECARE, INTERNATIONAL HOME CARE SERVICES OF NY, LLC, JUST CARE LLC, SAFE HAVEN HOME CARE, INC., SAFETY 1ST HOMECARE, INC., SILVER LINING HOMECARE AGENCY, INC., SUNDANCE HOME CARE INC., ALLCARE HOMECARE AGENCY, INC. DBA VIVID CARE Plaintiffs, v. NEW YORK STATE, NEW YORK STATE DEPARTMENT OF HEALTH, KATHY HOCHUL, in her official capacity as Governor of New York State, and JAMES V. MCDONALD, in his official capacity as Commissioner, New York State Department of Health Defendants.	)	Civil Action No.: 1:24-cv-05896

DECLARATION OF DEREK ADAMS IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

I, Derek Adams, hereby affirm under penalty of perjury pursuant to 28 U.S.C. § 1746, as follows:

1. I am an attorney and a partner of the law firm Potomac Law Group, PLLC, representing Plaintiffs in the above-captioned matter.

2. The purpose of this declaration is to authenticate certain documents that are relevant to this matter.

3. Attached to this declaration as Appendix 1 is a true and accurate copy of currently published dates by Defendant New York State Department of Health ("NYSDOH") for Request for Proposals #20524.

4. Attached to this declaration as Appendix 2 is a true and correct copy of the RFP 20524 Questions Submission from Ashley Navarro made to OHIPcontracts@health.ny.gov on June 27, 2024. In this submission, various questions were posed to Defendant NYSDOH, including the following:

a. "Will the Department be submitting one or more State Plan Amendments to address the changes to CDPAP services in New York? If so, when?"

b. "Will the Department be submitting a Section 1915B waiver to address the changes to CDPAP services in New York?"

c. "If an amendment to the Community First Choice Option State plan is planned, when does the Department intent [sic] to submit this to CMS and will a draft amendment be made available to the applicants?"

5. Defendant NYSDOH issued its purported responses to questions it received pertaining to RFP 20524 on August 7, 2024, a true and correct copy of which is attached hereto as Appendix 3. *See also* https://www.health.ny.gov/funding/rfp/20524/qanda.pdf. Defendant NYSDOH, however, did not include the questions posed above on its list, nor did it answer these questions.

6. Attached to this declaration as Appendix 4 is a true and correct copy of a 2001 State Medicaid Director Letter, SMDL #01-006, also available at https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd011001a.pdf. *See* Compl. ¶ 129.

7. Attached to this declaration as Appendix 5 is a true and correct copy of a Washington State Section 1915(b) Waiver Request for its Consumer Directed Employer program, submitted to the U.S. Department of Health and Human Services ("HHS"), also available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/WA-15.pdf. *See* Compl. ¶ 66.

8. Attached to this declaration as Appendix 6 is a true and correct copy of an approval letter by HHS in response to Washington State's Section 1915(b) Waiver Request, also available at https://www.medicaid.gov/Medicaid/spa/downloads/WA-21-0011.pdf.

9. Attached to this declaration as Appendix 7 is a true and correct copy of New York's State Plan Amendment 13-0035, adding the Community First Choice State Plan Option, effective July 1, 2015, as approved by CMS via letter dated October 23, 2015, also available at https://www.health.ny.gov/regulations/state_plans/status/non-inst/approved/docs/app_2015-10-23_spa_13-35.pdf. *See* Compl. ¶ 114.

10. Attached to this declaration as Appendix 8 is a true and correct copy of CMS State Medicaid Director Letter #16-011 RE: Community First Choice State Plan Option, dated December 30, 2016, also available at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd16011.pdf. *See* Compl. ¶ 118.

11. Attached to this declaration as Appendix 9 is a true and correct copy of a Section 1915(b) Waiver Request for Crisis Services for Individuals with Intellectual and Developmental Disabilities submitted by NYSDOH to HHS, also available at https://www.health.ny.gov/regulations/state_plans/status/non-inst/1915_b4_waiver/docs/2019/os_2020-02-26_1915b4_19-14.pdf. *See* Compl. ¶ 67.

12. Attached to this declaration as Appendix 10 is a true and correct copy of the August 31, 2012 section 1115 demonstration approval letter from the U.S. Centers for Medicare and Medicaid Services ("CMS") to Defendant NYSDOH, also available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/Federal-State-Health-Reform-Partnership/ny-f-shrp-concurrent-amendment-approval-08312012.pdf. *See* Compl. ¶ 104.

13. Attached to this declaration as Appendix 11 is a true and correct copy of the January 9, 2024 approval letter from CMS to Defendant NYSDOH, approving New York's request to amend its Medicaid section 1115(a) demonstration entitled "Medicaid Design Team," also available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ny-medicaid-rdsgn-team-appvl-01092024.pdf. *See* Compl. ¶ 104.

14. Attached to this declaration as Appendix 12 is a true and correct copy of the Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of

the Americans with Disabilities Act and *Olmstead v. L.C*, also available at https://www.ada.gov/resources/olmstead-mandate-statement/. *See* Compl. ¶¶ 147-148.

15. Attached to this declaration as Appendix 13 is a true and correct copy of the Report and Recommendations of the Olmstead Cabinet, New York State, October 2013, also available at https://www.ny.gov/sites/default/files/atoms/files/Olmstead_Final_Report_2013.pdf. *See* Compl. ¶ 149.

Dated: August 27, 2024

Respectfully submitted,

/s/ Derek Adams

Derek Adams (N.Y. Registration 5976790)
Potomac Law Group, PLLC
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APPENDIX 1

New York State Fiscal Intermediary Services

Request for Proposals #20524

Issued: June 17, 2024

Calendar of Events

Issuance of Request for Proposals	June 17, 2024
Deadline for Submission of Written Questions	Questions Due By July 2, 2024 by 4:00 p.m. ET
Responses to Written Questions Posted by DOH	On or About **August 7**, 2024 by 4:00 p.m. ET
Deadline for Submission of Proposals	Proposals Due on Or Before **August 21**, 2024 by 4:00 p.m. ET
***Anticipated* Contract Start Date**	October 1, 2024

Contact Information

Designated Contacts

Pursuant to State Finance Law §§ 139-j and 139-k, the New York State Department of Health (hereinafter referred to as the Department or as DOH) identifies the following designated person to whom all communications attempting to influence the Department's conduct or decision regarding this procurement must be made.

- *Eryn Keefe*
  Bureau of Contracts
  New York State Department of Health
  Corning Tower, Room 2827
  Albany, NY 12237
  Phone: (518) 474-7896
  Email: Eryn.Keefe@health.ny.gov

Permissible Subject Matter Contact

Pursuant to State Finance Law § 139-j(3)(a), the Department identifies the following allowable person to contact for communications related to the submission of written bids, written questions, pre-bid questions, and debriefings.

- *Michael Lewandowski*
  New York State Department of Health
  Office of Health Insurance Programs
  Division of Finance and Rate Setting
  Telephone: Telephone: 518-473-4657
  Email Address: OHIPContracts@health.ny.gov

Documents

- Request for Proposals (PDF)
- Amendment 1 (PDF)
- Amendment 2 (PDF)
- Amendment 3 (PDF)
- Questions and Answers (PDF)

APPENDIX 2

From: Ashley N.
To: OHIPContracts@health.ny.gov
Subject: RFP Questions Submission - 6/27/2024
Date: Thursday, June 27, 2024 5:20:59 PM
Attachments: RFP Questions.docx

Hi,

Please find the attached RFP questions.

As per Request for Proposals (RFP #20524), Section 5.2 Questions, all questions and requests for clarification shall cite the particular RFP Section and paragraph number where applicable. It is the bidder's responsibility to ensure that the email containing written questions and/or requests for clarification is received no later than the Deadline for Submission of Written Questions, on July 2, 2024, by 4:00 PM, with the acknowledgment that questions received after the deadline may not be answered. Furthermore, as per Section 1.0 Calendar of Events, responses to written questions posted by DOH, shall be received on or about July 19, 2024.

Thank you for your anticipated response.

Regards,

Ashley Navarro
Cell (917) 602-1025

Questions to ask the New York State Department of Health (NYSDOH) for clarity regarding the Request for Proposal (RFP) #20524 for Statewide Fiscal Intermediary Services:

Timeframe of Addressing Changes Clarifications:

Section 1.0, Calendar of Events:

1. Will the Department be submitting one or more State Plan Amendments to address the changes to CDPAP services in New York? If so, when? (RFP Section 1.0, Calendar of Events)
2. Will the Department be submitting a Section 1915B waiver to address the changes to CDPAP services in New York? If so, when? (RFP Section 1.0, Calendar of Events)

Eligibility Clarification:

Section 3.1, Minimum Qualifications:

3. What specific documentation is required to demonstrate that our organization meets the minimum qualifications as a fiscal intermediary as outlined in Section 3.1 of the RFP? (RFP Section 3.1, Minimum Qualifications, para. a)

Service Scope Clarification:

Section 2.1, Background Information:

4. Can you provide more detailed definitions of "consumer peer support" and "education and training" as required services, as outlined in Section 2.1 of the RFP? (RFP Section 2.1, Background Information, para. 2)

Best Practices and CHRC Requirements Clarification:

Section 4.2, Best Practices:

5. According to Section 4.2 of the RFP, which includes conducting visits to the consumer's home, is there a law or specific requirement for Criminal History Record Checks (CHRC) for staff providing in-home visits? (RFP Section 4.2, Best Practices, para. 1b)

Development and Implementation Council Contact. Clarifications:

Section 4.4, Statewide Fiscal Intermediary Compliance Requirements:

6. If an applicant provides statewide Fiscal Intermediary services in State that does not provide the Community First Choice Option, should the applicant review the current NYS CFCO State plan to ensure compliance, or will there be an amendment to the NYS CFCO State Plan before the Statewide FI is implemented? (RFP Section 4.4, Statewide Fiscal Intermediary Compliance Requirements)

Section 5.3, Right to Modify RFP:

7. If an amendment to the Community First Choice Option State plan is planned, when does the Department intent to submit this to CMS and will a draft amendment be made available to the applicants? (RFP Section 5.3, Right to Modify RFP, para. 1)

Section 4.2, Best Practices:

8. To ensure that best practices are person centered and driven by Consumers, caregivers or advocates is there a contact for the Development and Implementation Council (42 CFR § 441.575) to discuss best practices in Section 4.2 related to this RFP? (RFP Section 4.2, Best Practices, para. 1)

Joint Employment Clarification:

Section 4.3, Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements:

9. Can you elaborate on the joint employment responsibilities outlined in Section 4.3, particularly regarding wage setting and benefit coordination. (RFP Section 4.3, Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements)

Transition Requirements Clarifications:

Section 4.10, Transition Requirements:

10. What are the specific data transfer and documentation requirements for the transition period described in Section 4.10? (RFP Section 4.10, Transition Requirements, para. 2-4)
11. Why must the plan and documentation for transition be submitted at least 6 months prior to the transition? (RFP Section 4.10, Transition Requirements, para. 4)
12. What are the requirements of the contractor to ensure appropriate transition occurs between current FIs and the awarded contractor? (RFP Section 4.10, Transition Requirements)

13. What records will the awarded contractor be required to obtain from the current FIs? (RFP Section 4.10, Transition Requirements)
14. What if the awarded contractor's technology system(s) differ from those used by the current FIs? (RFP Section 4.10, Transition Requirements, para. 2-4)
15. Will the Department provide any funding for the transition from current FIs to the awarded contractor? (RFP Section 4.10, Transition Requirements)

Quality Monitoring Clarification:

Section 4.7, Quality Monitoring and Reporting Requirements:

16. What specific quality measures and reporting requirements will be expected from the awarded Statewide Fiscal Intermediary (FI), as outlined in Section 4.7 of the RFP? (RFP Section 4.7, Quality Monitoring and Reporting Requirements, para. 1-2)

Provider Status Under NYS Social Services Law Clarification:

Section 4.4, Statewide Fiscal Intermediary Compliance Requirements:

17. Will the statewide Fiscal Intermediary (FI) be considered a provider under NYS Social Services Law (SOS) § 363-d, as outlined in Section 4.4 of the RFP? (RFP Section 4.4, Statewide Fiscal Intermediary Compliance Requirements)

Compliance Program and Claims Risk Clarification:

Section 4.4, Statewide Fiscal Intermediary Compliance Requirements:

18. If the statewide Fiscal Intermediary (FI) does not have an effective compliance program, considering it is the only FI, will all the claims be at risk for recoupment for that period, as outlined in Section 4.4 of the RFP (RFP Section 4.4, Statewide Fiscal Intermediary Compliance Requirements)

Staffing Clarifications:

Section 4.5, Fiscal Intermediary Organizational Requirements:

19. Section 4.5 of the RFP provides that the awarded contractor shall have and maintain an effective organizational structure with qualified administrative staff. How many administrative staff is the awarded contractor anticipated by the Department to maintain? (RFP Section 4.5, Fiscal Intermediary Organizational Requirements, para. 1b)

20. Section 4.5 of the RFP also states that the awarded contractor must maintain a local presence in each region of the state. Does this mean at least one office in each of the 4 rate regions? Or does this mean at least one office in each county throughout New York state? Or something else? (RFP Section 4.5, Fiscal Intermediary Organizational Requirements, para. 1g)

Section 5.5, Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting:

21. Why does the Department believe there is not a single qualified MBE or WBE that can be the awarded contractor? (RFP Section 5.5, Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting, para. 1)

PACE Program and Fiscal Intermediary Services Clarifications:

Section 4.1, Required Fiscal Intermediary Services:

22. Under the new regulations for PACE, a PACE applicant must be approved under section 365-f of the New York State Social Services Law (SSL). Is a PACE program required to submit a response to provide Fiscal Intermediary services as part of this RFP? (RFP Section 4.1, Required Fiscal Intermediary Services)

Section 2.1 Background Information:

23. May a PACE Plan contract for Fiscal Intermediary services with an entity, other than the winning statewide FI? (RFP Section 2.1 Background Information, para. 3)

Technology Requirements and Healthcare Sector Cybersecurity Clarifications

Section 4.8, Information Technology Requirements:

24. Given the heightened vulnerability of the healthcare sector to cybersecurity risks and the significant increase in cyber incidents, particularly ransomware attacks, tracked by the U.S. Department of Health and Human Services (HHS), will the Department of Health (DOH) allow the use of overseas call centers, consultants, or subcontractors to support the awarded Statewide Fiscal Intermediary (FI)? (RFP Section 4.8, Information Technology Requirements, para. 1)
25. Will the DOH review and approve the use of out-of-state administrative work to ensure compliance with cybersecurity standards and protect sensitive data? Per the NYS-P03-002 Information Security Policy, Section 4.4, Information Risk Management, risk

assessments must include additional considerations when systems, services, or information will reside, or be accessed from, outside of the Contiguous United States (CONUS) to ensure compliance with relevant statutory, regulatory, and contractual requirements. Risk assessment results, and the decisions made based on these results, must be documented. (RFP Section 4.8, Information Technology Requirements, para. 1)

Disclosure of Use of Overseas Call Centers or Administrative Services Clarification:

Section 4.8, Information Technology Requirements:

26. If the qualified bidder has provided statewide FI services in another state using overseas call centers or administrative services contracted to overseas entities, should this be disclosed in the response to the RFP? Additionally, what specific documentation or information should be included to ensure full transparency and compliance with NYSDOH requirements? (RFP Section 4.8, Information Technology Requirements, para. 1)

Financial Oversight Clarifications:

Section 4.6, Fiscal Monitoring and Oversight Requirements:

27. What are the details of the required fiscal procedures and internal controls mentioned in Section 4.6? (RFP Section 4.6, Fiscal Monitoring and Oversight Requirements, para. 1b)

Section 5.6.2, Revolving Credit Facility:

28. Where did the Department come up with the $100 million figure for a required line of credit? (RFP Section 5.6.2 Revolving Credit Facility, para. 1)
29. What is the $100 million figure for a required line of credit based on? (RFP Section 5.6.2 Revolving Credit Facility, para. 1)

Compliance Reporting Clarification:

Section 4.7, Quality Monitoring and Reporting Requirements:

30. How frequently will the awarded FI need to submit compliance reports, and what specific content will these reports need to include, as outlined in Section 4.7 of the RFP? (RFP Section 4.7, Quality Monitoring and Reporting Requirements, para. 1-2)

Home and Community-Based Setting Clarifications:

Section 4.4, Statewide Fiscal Intermediary Compliance Requirements:

31. According to 42 CFR § 441.530 Home and Community-Based Setting, the setting must facilitate individual choice regarding services and supports, and who provides them. Will the statewide Fiscal Intermediary (FI) be considered a home and community-based setting under this regulation, as per the compliance requirements outlined in Section 4.4 of the RFP? (RFP Section 4.4, Statewide Fiscal Intermediary Compliance Requirements)

Section 3.1, Minimum Qualifications:

32. According to 42 CFR § 441.530 Home and Community-Based Setting, the setting must facilitate individual choice regarding services and supports, and who provides them. To facilitate choice, can additional subcontractors be included in the bid? (RFP Section 3.1, Minimum Qualifications)

Training and Orientation Clarification:

Section 4.1, Required Fiscal Intermediary Services:

33. Are there specific training materials or orientation processes that the Department recommends or requires for personal assistants, as outlined in Section 4.1 of the RFP? (RFP Section 4.1, Required Fiscal Intermediary Services, para. 4b)

Consumer Responsibilities Clarification:

Section 4.1, Required Fiscal Intermediary Services:

34. What specific support will be provided by the Department to ensure consumers understand and fulfill their responsibilities under the Consumer Directed Personal Assistance Program (CDPAP), as outlined in Section 4.1 of the RFP? (RFP Section 4.1, Required Fiscal Intermediary Services, para. 4)

Cultural Competency Clarification:

Section 4.5, Fiscal Intermediary Organizational Requirements:

35. What criteria will be used to assess the cultural and language competencies of the bidder's staff and subcontractors, as outlined in Section 4.5 of the RFP? (RFP Section 4.5, Fiscal Intermediary Organizational Requirements, para. 1e)

36. Will overseas or offshore subcontractors be allowed to ensure the cultural and language competencies of the bidder's staff and subcontractors, as outlined in Section 4.5 of the RFP? (RFP Section 4.5, Fiscal Intermediary Organizational Requirements, para. 1e)

Conflict of Interest Clarifications:

Section 4.5, Fiscal Intermediary Organizational Requirements:

37. What specific steps should a bidder take to avoid perceived conflicts of interest, particularly if they have relationships with LHCSAs or MCOs? (RFP Section 4.5, Fiscal Intermediary Organizational Requirements, para. 1d)

Section 5.13 Vendor Assurance of No Conflict of Interest or Detrimental Effect:

38. Under 42 CFR Part 438, which outlines requirements for managed care organizations, and 42 CFR Part 441, which addresses requirements for home and community-based services, including conflict of interest standards for care managers and service coordinators, does the conflict of interest only pertain to a Licensed Home Care Services Agency (LHCSA) providing service coordination services under a 1915(c) waiver, as mentioned in Section 5.13 of the RFP? (RFP Section 5.13 Vendor Assurance of No Conflict of Interest or Detrimental Effect, para. 1)

Insurance Requirements Clarification:

Section 5.6, Data Breach and Privacy/Cyber Liability including Technology Errors and Omissions:

39. Can you provide more detail on the insurance requirements, particularly the Data Breach and Privacy/Cyber Liability Insurance, as outlined in Section 5.6 of the RFP? (RFP Section Data Breach and Privacy/Cyber Liability including Technology Errors and Omission, para. 1-2)

Vendor Responsibility Clarification:

Section 6.1.3, Vendor Responsibility Questionnaire:

40. What specific elements will be assessed in the Vendor Responsibility Questionnaire, as outlined in Section 6.1.3 of the RFP? (RFP Section Vendor Responsibility Questionnaire)

MWBE Participation Clarification:

Section 5.5, Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting:

41. Even with a 0% goal for MWBE participation, are there still benefits or preferences for engaging MWBE firms, as outlined in Section 5.5 of the RFP? (RFP Section 5.5, Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting)

Number of Subcontractors Clarifications:

Section 4.5, Fiscal Intermediary Organizational Requirements:

42. According to Section 4.5 of the RFP, the awarded Statewide Fiscal Intermediary (FI) will work with subcontractors and entities throughout the state. Is there a limit to the number of subcontractors that can be included in the bid? (RFP Section Fiscal Intermediary Organizational Requirements, para. 1a)

Section 4.0, Fiscal Intermediary Scope of Work:

43. How many entities would fit the requirements of the Department's pre-January 1, 2012, criteria? (RFP Section 4.0, Fiscal Intermediary Scope of Work)

Subcontractors Clarifications:

Section 5.7, Subcontracting:

44. What specific qualifications are required for subcontractors to be approved by the Department of Health, as outlined in Section 5.7 of the RFP? (RFP Section 5.7, Subcontracting, para. 1)
45. How should the specific qualifications, which are required for subcontractors to be approved by the Department of Health, be documented in the bid submission? (RFP Section 5.7, Subcontracting)

MWBE Participation Clarification:

Section 5.5, Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting:

46. While there is a 0% goal for MWBE participation, would the use of small, culturally appropriate Fiscal Intermediaries (FIs) as subcontractors be considered beneficial in the bid, as outlined in Section 5.5 of the RFP? (RFP Section 5.5, Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting)

Freedom of Information Law Clarification:

Section 5.9, Freedom of Information Law ("FOIL):

47. How should sensitive information be marked and justified as exempt from disclosure under FOIL? (RFP Section 5.9, Freedom of Information Law ("FOIL), para. 1)

Audit Requirements Clarification:

Section 4.6, Fiscal Monitoring and Oversight Requirements

48. What specific audit procedures and documentation will the Department require from the Fiscal Intermediary (FI), as outlined in Section 4.6 of the RFP? (RFP Section 4.6, Fiscal Monitoring and Oversight Requirements, para. 1c and g)

Subcontractor Agreements Clarifications:

Section 5.7, Subcontracting:

49. Is there any requirement that all subcontractor work must be performed in New York State, as outlined in Section 5.7 of the RFP? (RFP Section 5.7, Subcontracting)
50. If not any requirement that all subcontractor work must be performed in New York State, is there a percentage of work that must be performed in-state, as outlined in Section 5.7 of the RFP? (RFP Section 5.7, Subcontracting)

APPENDIX 3

New York State Department of Health
Request For Proposals (RFP) #20524
New York State Fiscal Intermediary Services
Questions and Answers - August 7, 2024

Number	Subject	Corresponding RFP Section	Question	Answer
1	2012 Requirement	Section 4.0: Scope of Work (Page 5 of RFP)	How many entities would fit the requirements of the Department's pre-January 1, 2012, criteria?	This question is not relevant to the development of a proposal under this RFP.
2	2012 Requirement	Section 4.0: Scope of Work, Paragraph 1 (Page 5 of RFP)	Will a subcontractor candidate be required to provide a billing claim from December 31, 2011 or earlier?	No, such information will be validated with NYS systems
3	2012 Requirement	Section 4.0: Scope of Work, Paragraph 1 (Page 5 of RFP)	If January 1, 2012 is the first date service was billed, is that fiscal intermediary eligible to be a subcontractor?	Please refer to Social Services Law Section 365-f.
4	2012 Requirement	Section 4.0: Scope of Work, Paragraph 1 (Page 5 of RFP)	If an organization was formed December 31, 2011, but did not bill for service until January 2, 2012, is that fiscal intermediary eligible to be a subcontractor?	Please refer to Social Services Law Section 365-f.
5	Advisory Committee	Section 4.2: Best Practices, Bullet e) (Page 6 of RFP)	Does a bidder need to provide a description of its proposed consumer advisory committee as part of its proposal?	If the bidder is proposing an advisory committee as part of its Technical Proposal, the bidder should include such information in accordance with Section 6.2.F.2 of the RFP.
6	Advisory Committee	Section 4.2: Best Practices, Bullet e) (Page 6 of RFP)	How will the Department evaluate the consumer advisory committee as part of its proposal review?	The specific components of the Department's evaluation will not shared with the bidding community.
7	Advisory Committee	Section 4.2: Best Practices, Bullet e) and f) (Page 6 of RFP)	We agree that establishing a consumer advisory committee an accessible forum of useful information for consumers, are examples of best practices. Is the Department aware of any examples of these to help elicit more ideas from the bidders?	No.
8	Advisory Committee	Section 4.2: Best Practices, Bullet a) (Page 6 of RFP)	When does the Statewide FI need to establish a consumer advisory committee by?	See answer to Question #5
9	Advisory Committee	Section 4.2: Best Practices, Bullet e) (Page 6 of RFP)	What is the timeline for the Statewide FI to establish a consumer advisory committee once the contract is awarded?	See answer to Question #5
10	Advisory Committee	Section 4.2: Best Practices, Bullet e) (Page 6 of RFP)	What is the specific recommended composition of a consumer advisory committee?	See answer to Question #5
11	Advisory Committee	General	If the consumer advisory committee includes PAs, FI staff, MCOs & LDSS how many of each category?	See answer to Question #5
12	Advisory Committee	General	What is the frequency of consumer advisory committee meetings?	See answer to Question #5
13	Advisory Committee	General	Will travel expenses to attend the consumer advisory committee be provided?	See answer to Question #5
14	Advisory Committee	General	Will the consumer advisory committee the statewide or regional?	See answer to Question #5
15	Advisory Committee	General	Would the consumer advisory committee be the responsibility of the statewide FI or the subcontractors?	See answer to Question #5
16	Auditing	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet i) (Page 8 of RFP)	Will pending audit information be available to the public?	As stated in Section 6.2.F.4.2 of the RFP, Bidders should provide a description of the audits and could be open to release upon FOIL.
17	Auditing	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	The RFP states that bidders must "Provide a description of all pending audits related to fiscal intermediary services, both in New York and other states where the awarded Statewide FI is currently or has been operating." Does this include any active or pending lawsuits or legal actions being taken against the bidder in New York or another state?	Bidders should disclose pending audits pursuant to Section 6.2.F.4.2; active or pending lawsuits and legal actions would be disclosed on the Bidder's Vendor Responsibility Questionnaire.
18	Auditing	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet i) (Page 8 of RFP)	Does a proposed fiscal intermediary need to disclose concluded audits into fiscal intermediary services or only audits that are pending?	A description of all concluded or pending audits related to fiscal intermediary services in New York State or other states should be included.
19	Auditing	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet i) (Page 8 of RFP)	Does a proposed fiscal intermediary need to disclose concluded, pending and/or current litigation, including litigation concerning prior fiscal intermediary services and/or litigation concerning alleged nonpayment of wages?	RFP Section 4.5.i only relates to audits. Litigation disclosure is required as part of the Vendor Responsibility Questionnaire.
20	Auditing	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet i) (Page 8 of RFP)	Are the audits referenced limited to Medicaid audits?	No. Audits are as related to fiscal intermediary services both in New York State and other states where the organization is currently or has been operating.

New York State Department of Health
Request For Proposals (RFP) #20524
New York State Fiscal Intermediary Services
Questions and Answers - August 7, 2024

Number	Subject	Corresponding RFP Section	Question	Answer
21	Auditing	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Can the Department of Health provide a list of current fiscal intermediary entities that are on an OIG or OMIG exclusion list?	OMIG Medicaid exclusion information can be found here: https://omig.ny.gov/medicaid-fraud/medicaid-exclusions. OIG exclusion information can be found here: https://oig.hhs.gov/exclusions/exclusions_list.asp
22	Auditing	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	What specific audit procedures and documentation will the Department require from the Fiscal Intermediary (FI), as outlined in Section 4.6 of the RFP?	Specific audit procedures will be established between the awardee and the Department.
23	Auditing	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet i) (Page 8 of RFP)	Does a proposed fiscal intermediary need to disclose pending and/or current investigations?	Yes
24	Auditing	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet i) (Pages 6-7 of RFP)	What information is collected and evaluated in auditing a consumer's billing records?	This question is not relevant to the development of a proposal under this RFP.
25	Auditing	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet i) (Pages 6-7 of RFP)	Will overtime hours be included in auditing a consumer's billing records?	This question is not relevant to the development of a proposal under this RFP.
26	Auditing	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet i) (Pages 6-7 of RFP)	Does the auditing process of billing records include a total assessment of the cost of a consumer's care?	This question is not relevant to the development of a proposal under this RFP.
27	Award	Section 8.7: Award Recommendation (Page 27 of RFP)	Will the New York State Comptroller review any proposed Department award to assure that the Department has complied with the law and the terms of the RFP?	No. The resulting contract will not be subject to the Office of State Comptroller's approval.
28	Award	Section 2.0: Overview and Important Information (Page 3 of RFP)	Section 2.0 states that it is the Department's intent to award one (1) contract from this procurement. Up until this RFP, there have been a great many of fiscal intermediaries in the state of New York. Reducing this number from hundreds to one is both illogical and unduly restrictive. Awarding only a single provider can also cause extreme disruption in the program should that provider fail to perform its responsibilities. Accordingly, can this be removed from the RFP such that this can be a multi-vendor award?	No.
29	Award	Section 2.0: Overview and Important Information (Page 3 of RFP)	The RFP states that the Department's intent is to award one contract. Can the Department award more than one contract?	No.
30	Award	Section 2.0: Overview and Important Information (Page 3 of RFP)	If the Department can award more than one contract, under what circumstances would the Department award more than one contract?	The Department will only award one contract under this RFP.
31	Award	Section 1.0: Calendar of Events (Page 3 of RFP)	What is the expected date lead FI be announced?	Please see the Calendar of Events on page 1 of the RFP.
32	Award	Section 1.0: Calendar of Events (Page 3 of RFP)	The Calendar of Events indicates a contract start date of October 1, 2024, but does not include a contract award date. When does the Department anticipate making a contract award?	The Department will notify the selected bidder of its award within a timeframe which will allow for the anticipated October 1, 2024 contract start date.
33	Award	Section 2.1: Background Information, Paragraph 3 (Page 3 of RFP)	The statute New York Consolidated Laws, Social Services Law, SOS § 365-f requires the selection of a single Statewide Fiscal Intermediary. However, the legislative intent and specific implementation details remain broad and unclear. Could the Department clarify the specific criteria	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
34	Award	General	How many Fiscal Intermediary Agencies New York State Health Department is going to award? Only one or as many as qualified?	There will be one award resulting from RFP #20524. See Section 2.0 of the RFP.

New York State Department of Health
Request For Proposals (RFP) #20524
New York State Fiscal Intermediary Services
Questions and Answers - August 7, 2024

Number	Subject	Corresponding RFP Section	Question	Answer
35	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Are current FIs obligated to provide PA documentation regarding background checks to the awarded FI?	Background checks are not a current requirement of CDPAP.
36	Background Checks	Section 4.2: Best Practices (Page 6 of RFP)	According to Section 4.2 of the RFP, which includes conducting visits to the consumer's home, is there a law or specific requirement for Criminal History Record Checks (CHRC) for staff providing in-home visits?	It is not anticipated by the Department that staff of the contracted Statewide Fiscal Intermediary who conduct visits to consumers have background checks completed. However, it would be expected that the Statewide Fiscal Intermediary and its subcontractors would vet their employees as standard practice to ensure they are capable of performing their responsibilities in an effective and appropriate manner.
37	Background Checks	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Is the FMS provider responsible for employee background checks? If yes, please provide the requirements for employee background checks.	The implementation and specifics of the background check requirement for personal assistants is still being determined. The cost of a background check should not be factored into a bidder's cost proposal.
38	Background Checks	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	If employee background checks are required, how are they paid for? A) Reimbursed through the Participant's Budget, B) Reimbursed by the Program, or C) Covered by the FMS via its Admin Fee?	See answer to Questions #35 and #37
39	Background Checks	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Is the FMS provider responsible for employee background checks? If yes, please provide the requirements for employee background checks.	See answer to Questions #35 and #37
40	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	This section includes the following language: "as well as documentation, where applicable, of completed background checks and completed training requirements." Background checks and training are not fiscal intermediary services under 365-f. Please confirm that the applicant is not required to address these items.	See answer to Questions #35 and #37
41	Background Checks	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Sections 4.1 (e) and 4.4 (h) state, "…documentation, where applicable, of completed background checks and completed training requirements…" Are background checks now required for personal assistants? If so, what type of background checks will be required, and are they required for all personal assistants?	See answer to Questions #35 and #37
42	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Maintaining personnel records for each PA, including time records and other documentation needed for wages and benefit processing and a copy of the medical documentation required above by 4.1(b), as well as documentation, where applicable, of completed background checks and completed training requirements; At this time, there are no requirements for background check processing from the third-party fiduciary, when awarded will the fiscal intermediary be expected to perform background checks? If so, what is included?	See answer to Questions #35 and #37
43	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	How will background checks be paid for? Will they be deducted from the budget, paid for by the worker, paid via administrative billing and invoice to the state or MCO, or paid out of the PMPM?	See answer to Questions #35 and #37
44	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Who will be paying for a background check?	See answer to Questions #35 and #37
45	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Will the background check be an administrative or direct care cost?	See answer to Questions #35 and #37
46	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Is there an anticipated length of time that a background check should take to perform?	See answer to Questions #35 and #37
47	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	What in a background check will preclude a PA from working?	See answer to Questions #35 and #37
48	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Will the results of the background check be conveyed to the consumer?	See answer to Questions #35 and #37

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49	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Will the consumer have any right to accept what's discovered in the background check?	See answer to Questions #35 and #37
50	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	How long will it take for the background check to be completed?	See answer to Questions #35 and #37
51	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet f) (Page 5 of RFP)	Will there be exceptions or special procedures for the maintenance of personal records if either a consumer or PA has a legitimate claim of privacy and confidentiality due to being a domestic violence victim?	See answer to Questions #35 and #37
52	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Please list the background checks required of the direct care staff.	See answer to Questions #35 and #37
53	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Do any background checks require in-person fingerprints?	See answer to Questions #35 and #37
54	Background Checks	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	Can the Department of Health specify the specific background check policies that will be required?	See answer to Questions #35 and #37
55	Background Checks	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	Is the consumer required to submit completed background checks and training to the Statewide FI?	See answer to Questions #35 and #37
56	Background Checks	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	Is the Statewide FI or the consumer supposed to complete background checks?	See answer to Questions #35 and #37
57	Background Checks	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	What background checks are required, and who is responsible for carrying them out, the Statewide FI or the consumer?	See answer to Questions #35 and #37
58	Background Checks	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	What “completed background checks” and “completed training requirements” are referenced?	See answer to Questions #35 and #37
59	Background Checks	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	In what circumstances must background checks be completed?	See answer to Questions #35 and #37
60	Background Checks	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	Will the selected FI be required to perform background checks on PAs?	See answer to Questions #35 and #37
61	Background Checks	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	Will Consumers be required to adhere to the results of those background checks?	See answer to Questions #35 and #37

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62	Background Checks	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	Who will pay for the background checks?	See answer to Questions #35 and #37
63	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Is the cost of the background check incorporated into the PMPM?	See answer to Questions #35 and #37
64	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Would the state be willing to pay the direct cost of background checks outside of the PMPM?	See answer to Questions #35 and #37
65	Background Checks	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Section 4.1 (e) states that personnel records should include "documentation, where applicable, of completed background checks and completed training requirements." Given that background checks and training are not mandated under CDPAP regulations, why is this language included in the RFP? Does this refer to exclusion checks rather than background checks	See answer to Questions #35 and #37
66	Background Checks	General	Are background checks deducted from the budget?	See answer to Questions #35 and #37
67	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Can the Department provide clarification on the requirement to complete background checks, which is not in statute nor regulation, and conflicts with consumer direction?	See answer to Questions #35 and #37
68	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	What background checks are required for PAs in the CDPAP program?	See answer to Questions #35 and #37
69	Background Checks	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Will the SFI be responsible for employment history verifications going forward?	See answer to Questions #35 and #37
70	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	Will the consumer have the right to refuse peer mentoring provided by the statewide FI or subcontractor?	Yes.
71	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	Does a proposal need to include prior examples or experience of the bidder in pursuing these best practices or is it sufficient to describe an intention to use these best practices?	See Section 6.2.F.2 of the RFP.
72	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	How will these best practices be evaluated by the Department?	The specific components of the Department's evaluation will not shared with the bidding community.
73	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	What criteria will be used by the Department to evaluate the best practices?	The specific components of the Department's evaluation will not shared with the bidding community.
74	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	May the subcontractors provide part of the recommended Best Practices on behalf of the Single FI?	Yes.
75	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	Is there a requirement for the Single FI to provide some, if not all, of the recommended best practices?	No. As stated in Section 4.2 of the RFP, "In carrying out the specific duties described in Section 4.1, bidders may use creative approaches to assist in the delivery of high quality FI services that best meet the needs of consumers. Bidders should identify these approaches in Section 6.2 of the Technical Proposal.".
76	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	Are there examples of best practices that the Department can provide and/or are there specific New York State fiscal intermediaries that have pursued these best practices that the Department can reference?	No. See answer to Question #75
77	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	Considering the significant operational changes required to implement these best practices, will the Department provide guidance, support, or resources to the SFI and its subcontractors to facilitate compliance?	See answer to Question #75
78	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	Are there examples of “creative approaches” that the state considers exemplary?	See answer to Question #75
79	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	Is it a requirement that such entity, as part of its proven record, have pursued the identified best practices?	See answer to Question #75

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80	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	If FI's role is to perform administrative and financial functions, why are they required to develop and implement "best practices"?	See answer to Question #75
81	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	Will there by further guidance on implementing the best practices?	See answer to Question #75
82	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	How does this list of best practices relate to the requirements that one entity per NYS DOH MLTC rate setting have a proven record of delivering services to individuals with disabilities and the senior population?	See answer to Question #75 . Subcontractors may be involved in providing best practice services.
83	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	How will adherence to the "best practices" list in Section 4.2 be determined? What happens to SFI and subcontractors if they fail to adhere to them?	See answer to Question #75
84	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	What are the consequences for the SFI and its subcontractors if they fail to comply with the best practices described in Section 4.2, especially in the absence of specific statutory or regulatory backing?	See answer to Question #75
85	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	Are there any metrics or benchmarks for evaluating the effectiveness of these best practices?	The specific components of the Department's evaluation will not shared with the bidding community.
86	CDPAP Current Consumers	General	Is it accurate that individuals who require designated representatives, which would be a large chunk of the MLTC population, would no longer be considered eligible for the CDPAP program?	No.
87	CDPAP Current Consumers	General	Approximately how many individuals are receiving both CDPAP services and additional PCA services through agency care?	The Department does not have this information.
88	CDPAP Current Consumers	General	Approximately how many weekly hours are the current members allocated for? If that information is not available, what is the average number of authorized hours a member has available to them per year?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
89	CDPAP Current Consumers	General	What is the approximate cost of payroll for a given timeframe? Please specify the timeframe. For example, $100 million every two weeks.	The Department does not have this information.
90	CDPAP Current Consumers	General	Can you provide the number of consumers receiving less than 160 hours per month?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
91	CDPAP Current Consumers	General	Can you provide the number of consumers receiving more than 480 hours per month?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
92	CDPAP Current Consumers	General	What is the total number of participants self-directing in each program? What is the total volume of participants?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
93	CDPAP Current Consumers	General	How many individuals are currently and are projected to be served in this program?	Refer to RFP #20524 Attachment E. Projections will not be provided.
94	CDPAP Current Consumers	General	How many personal assistants are currently providing services through CDPAP?	The Department does not have this information.
95	CDPAP Current Consumers	General	What is the average turnover rate for personal assistants in the CDPAP program?	The Department does not have this information.
96	CDPAP Current Consumers	Section 4.1: Required Fiscal Intermediary Services, Paragraph 1 (Page 5 of RFP)	Recent claims of CDPAP's significant growth have been made without adequate supporting information. Can the Department provide detailed data on CDPAP's enrollment growth over the last 3-5 years, including any corresponding decreases in enrollment for related programs, such as personal care services? Additionally, please include data on the aging population trends during this period to contextualize these changes.	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
97	CDPAP Spend	Section 4.0: Scope of Work (Page 5 of RFP)	What was the total annual state spending for the CDPA program in CY 2023?	The total annual state spending for CDPAS in CY 2023 was approximately $4.5 Billion
98	CDPAP Spend	Section 4.0: Scope of Work (Page 5 of RFP)	What is the projected annual state spending for the CDPA program for SFY 2025?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
99	CDPAP Spend	General	What is the total monthly spending for all clients?	The Department cannot answer this question without additional information.

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100	CDPAP Spend	Attachment E: CDPAS Consumers by Region in December 2023 (Page 33 of RFP)	What is the projected growth of consumers for each year of the 5-year contract duration?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
101	CDPAP Spend	Attachment E: CDPAS Consumers by Region in December 2023 (Page 33 of RFP)	What is the projected growth of personal assistants for each year of the 5-year contract duration?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
102	CDPAP Spend	Section 4.0: Scope of Work (Page 5 of RFP)	How many personal assistants are currently active in the CDPA program?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
103	CDPAP Spend	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	How many Personal Assistants are there?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
104	CDPAP Spend	Section 4.1: Required Fiscal Intermediary Services, Bullet c) (Page 5 of RFP)	Regarding worker's compensation, how many PAs were issued W-2s in the CDPAP program for calendar year 2023?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
105	CDPAP Spend	Attachment E: CDPAS Consumers by Region in December 2023 (Page 33 of RFP)	Please provide the current number of personal assistants by each region.	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
106	CDPAP Spend	General	Can you provide a list of all the current FI vendors providing services to the population in the state?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
107	CDPAP Spend	General	How many participants is each FI serving?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
108	CDPAP Spend	General	How many FIs are currently providing, or estimated to provide, FI services to Consumers?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
109	CDPAP Spend	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	Can the Department provide comprehensive data reflecting the percentage increase in spending on CDPAP over the last 3-5 years, along with the corresponding percentage increase in home care worker minimum wage and wage-related fringe costs for the same period to contextualize these changes?	Bidders should review historic and publicly available information to inform their own assumptions.
110	CDPAP Spend	Section 4.0: Scope of Work (Page 5 of RFP)	What is the total value of the contract for the single FI? What is the total state spending on CDPAP during SFY 2023-24? What is projected spending for SFY 2024-25?	The total contract value will be based upon the awarded bidder's submitted Cost Proposal
111	CDPAP Spend	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	What was the total gross payroll for CDPAP for the last 5 calendar years and what is projected for 2024?	This amount is not currently being tracked by the State.
112	Complaints	Section 4.2: Best Practices, Bullet f) (Page 6 of RFP)	Does the "means to report and/or resolve complaints" include complaints by PAs about Consumers, or Consumers about PAs?	The statewide fiscal intermediary should have a means by which to report, refer and/or resolve any type of complaint from consumers and/or personal assistants.
113	Complaints	Section 4.2: Best Practices, Bullet f) (Page 6 of RFP)	If the "means to report and/or resolve complaints" include complaints by PAs about Consumers, or Consumers about PAs, what is the limit to a fiscal intermediary's ability to resolve complaints, as Social Services Law section 365-f(4-a)(a)(iii) prohibits fiscal intermediaries from training, supervising and terminating personal assistants?	See answer to Question #112
114	Complaints	Section 4.2: Best Practices (Page 6 of RFP)	What feedback mechanisms will be in place for consumers and personal assistants to report non-compliance or issues related to the implementation of these best practices, and how will the Department address such feedback?	See answer to Question #112
115	Complaints	Section 4.2: Best Practices (Page 6 of RFP)	Will the consumer be able to submit complaints directly to DOH concerning accessibility, functionality or lack of response to questions/complaints submitted through the email system or website?	Yes.

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116	Complaints	Section 4.2: Best Practices (Page 6 of RFP)	The RFP states that bidders may use creative approaches to assist in the delivery of high quality FI services. Among the best practices is "Establishing, maintaining, and monitoring an electronic email or an ADA compliant, user-friendly website that provides information to consumers and their identified supports and provide a means to report and/or resolve complaints and answer inquiries." Does this mean that the bidder is not required to have a means for the consumer to report and/or resolve complaints and answer inquiries?	See answer to Question #112.
117	Complaints	Section 4.2: Best Practices (Page 6 of RFP)	The RFP states that bidders may use creative approaches to assist in the delivery of high quality FI services. Among the best practices is "Establishing, maintaining, and monitoring an electronic email or an ADA compliant, user-friendly website that provides information to consumers and their identified supports and provide a means to report and/or resolve complaints and answer inquiries." Does this mean that the bidder may have a mechanism for reports and inquiries that is not monitored as long as it is not identified in the Best Practices?	No, the bidder may not have a mechanism for reports and inquiries that is not monitored.
118	Complaints	Section 4.10: Transition Requirements (Page 11 of RFP)	What process will exist for consumer or personal assistant grievances, complaints, concerns, or other intervention/communication?	See answer to Question #112.
119	Complaints	Section 4.10: Transition Requirements (Page 11 of RFP)	Who will be the arbiter of addressing consumer/personal assistant grievances?	See answer to Question #112.
120	Complaints	Section 8.1: General Information (Pages 25-26 of RFP)	The RFP states that DOH will evaluate each proposal based on the 'Best Value' concept which is further defined as 'optimizes quality, cost and efficiency.' The RFP is silent on consumer rights or due process. How does that factor into the RFP and subsequent award?	See answer to Question #112.
121	Compliance	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	Besides the letter of credit, how will the State ensure that the Single FI remains fiscally solvent?	The selected bidder will be responsible for complying with all applicable laws, rules, and regulations, both state and federal and will be subject to the corresponding applicable sanctions and penalties. The selected bidder will be expected to consult with its advisors to determine compliance.
122	Compliance	Section 4.5: Fiscal Intermediary Organizational Requirements, Paragraph 1 (Page 8 of RFP)	How will the Department ensure that the selected Statewide FI maintains financial solvency throughout the contract term?	The selected bidder will be responsible for complying with all applicable laws, rules, and regulations, both state and federal and will be subject to the corresponding applicable sanctions and penalties. The selected bidder will be expected to consult with its advisors to determine compliance.
123	Compliance	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	Will failure to provide quality services result in a monetary penalty to the Statewide FI?	The selected bidder will be responsible for complying with all applicable laws, rules, and regulations, both state and federal and will be subject to the corresponding applicable sanctions and penalties. The selected bidder will be expected to consult with its advisors to determine compliance.
124	Compliance	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	Are there any specific federal or state regulations that are particularly crucial for compliance that we should be aware of beyond what is listed?	The selected bidder will be responsible for complying with all applicable laws, rules, and regulations, both state and federal and will be subject to the corresponding applicable sanctions and penalties. The selected bidder will be expected to consult with its advisors to determine compliance.
125	Compliance	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	Will the statewide Fiscal Intermediary (FI) be considered a provider under NYS Social Services Law (SOS) § 363-d, as outlined in Section 4.4 of the RFP?	Yes
126	Compliance	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	Section 4.5 (a) states that the Statewide FI must serve any consumer in a statewide capacity. Will the Statewide FI be able to withdraw FI services for any reason?	No. The determination regarding eligibility lies exclusively with the local social services district or the consumer's Managed Care Plan.
127	Compliance	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	How can a Statewide FI remedy perceived conflicts of interest?	The Department and the awarded contractor will work collaboratively to remedy any perceived conflicts of interest.
128	Compliance	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	Given the critical nature of Medicaid provider enrollment, what specific benchmarks and performance indicators will the Department use to assess the readiness and capability of an out-of-state SFI during the enrollment process?	The Department and the awarded contractor will work collaboratively to ensure the readiness for transition to the contracted Statewide Fiscal Intermediary.

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129	Compliance	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	Will a corrective action plan be implemented if the Statewide FI does not meet quality and effectiveness standards?	This question is not relevant to the development of a proposal under this RFP. Reporting and compliance standards will be determined between the Department and the Statewide Fiscal Intermediary at the time of contract execution.
130	Compliance	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	How will corporate compliance issues be managed under the subcontracting relationship?	The contracted Statewide Fiscal intermediary is responsible for the performance of its subcontractors.
131	Compliance	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP) and Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	What are the Department's expectations for fiscal oversight and investigation of issues related to fiscal integrity?	See answer to Question #130.
132	Compliance	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP) and Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	How will the Department verify the compliance history and operational integrity of an out-of-state SFI applying for Medicaid enrollment, and what additional oversight measures will be put in place during the initial transition period?	The specific components of the Department's evaluation will not shared with the bidding community.
133	Compliance	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	The proposal to consolidate all operations under a single or regional fiscal intermediary raises significant concerns about conflicts of interest. How does the Department plan to address and mitigate these concerns to ensure fair and unbiased service delivery?	The specific components of the Department's evaluation will not shared with the bidding community.
134	Compliance	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	Because Consumer Directed Personal Assistance Services have been one of the only effective ways to get community-based Long Term Services and Supports and the Disability Community has expressed concerns that establishing a Statewide FI will restrict access to those services, what standards will be established to ensure that Disabled individuals are able to receive services in the Most Integrated Setting?	See answer to Question #130.
135	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	Is ownership or control by an LHCSA a conflict of interest that will preclude an award?	See RFP Section 6.2.C. and Attachment 4.
136	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	Is ownership or control by an MCO a conflict of interest that will preclude an award?	See RFP Section 6.2.C. and Attachment 4.
137	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	Is ownership or control of an LHCSA a conflict of interest that will preclude an award?	See RFP Section 6.2.C. and Attachment 4.
138	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	Is ownership or control of an MCO a conflict of interest that will preclude an award?	See RFP Section 6.2.C. and Attachment 4.
139	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	What criteria will the Department use to determine ownership?	See RFP Section 6.2.C. and Attachment 4.
140	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	What criteria will the Department use to determine control?	See RFP Section 6.2.C. and Attachment 4.
141	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	What criteria will the Department use to determine "controlling interest"?	See RFP Section 6.2.C. and Attachment 4.

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142	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	Is there a difference between "control" and "controlling interest"?	No.
143	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	The RFP speaks to perceived/actual conflict between the single FI and a LHCSA and/or MCO in NYS. The conflict assurance does not mention that perceived conflict, specifically. Is the LHCSA/MCO relationship a conflict that will be considered exclusionary for the purposes of the bid submission?	See RFP Section 6.2.C. and Attachment 4.
144	Conflict of Interest	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	How does the Department intend to address potential conflicts of interest and ensure compliance with both state and federal regulations when a single FI is expected to manage such a broad and diverse consumer base across the entire state?	The Department and the awarded contractor will work collaboratively to remedy any perceived conflicts of interest.
145	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	What specific steps should a bidder take to avoid perceived conflicts of interest, particularly if they have relationships with LHCSAs or MCOs?	The Department will review all information for alleviating perceived or actual conflicts of interest as outlined in a bidder's technical narrative.
146	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	Section 4.5 (d) references a conflict of interest with entities owned by a LHCSA or MCO. Does this conflict of interest apply to subcontractors?	Yes.
147	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP	Do subcontractors to the prime bidder also need to meet the conflict provision (where they cannot be both an FI and an LHCSA)?	Yes.
148	Conflict of Interest	Section 5.7: Subcontracting (Pages 15-16 of RFP)	How will the Department ensure that subcontractors meet the necessary standards and avoid potential conflicts of interest?	See RFP Section 6.2.C. and Attachment 4.
149	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	RFP Section 4.5 Paragraph D: "Ensure the avoidance of actual or perceived conflicts of interest while operating as the Statewide FI (see Section 6.2.C and Attachment 4). Actual or perceived conflicts may include but are not limited to: • An entity that is owned or controlled by a Licensed Home Care Services Agency (LHCSA) or a Managed Care Organization (MCO) in New York State or that owns or holds the controlling interest in a LHCSA or MCO in New York State;" What are examples of actual or perceived conflicts of interest in regards to LHCSA if the LHCSA has adequate firewalls (as stated in previous NYS workgroups and documents) including separate Staff, Payroll Department, EMR systems, etc.	See RFP Section 6.2.C. and Attachment 4. It is the responsibility of each bidder to fully disclose any actual or perceived conflicts of interest and to explain to the Department how it has or proposes to cure any actual or perceived conflicts of interest.
150	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	To what extent will DOH require bidders to specify their relationship with: (a) related companies that hold contracts with NY state government or (b) the connections of sub-contractors (unfortunately left unspecified in this RFP) to LHCAs and MCOs?	See RFP Section 6.2.C. and Attachment 4.
151	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	What does it mean to avoid actual or perceived conflicts of interest while operating as the Statewide FI, and that actual or perceived conflicts of interest may include but not are not limited to, an entity that is owned or controlled by a LHCSA or an MCO or that owns or holds the controlling interest in a LHCSA or MCO? Does this mean that an RFP bidder cannot be owned or controlled by, or have a controlling interest in a LHCSA (e.g., operate a LHCSA)? Is this an absolute bar? RFP Section 4.5(d) I, states, "Actual or perceived conflicts may include . . . ." Emphasis added. If it isn't an absolute bar but may constitute a conflict of interest, what criteria will be used to determine if it is a conflict of interest and what is the legal basis for that criteria? If it is an absolute bar, what is the legal basis for such a conclusion?	See RFP Section 6.2.C. and Attachment 4.
152	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP	The RFP contains the following language: "Actual or perceived conflicts may include but are not limited to an entity that is owned or controlled by a Licensed Home Care Services Agency (LHCSA) or a Managed Care Organization (MCO) in New York State or that owns or holds the controlling interest in a LHCSA or MCO in New York State." Will the Department provide language defining what a "perceived conflict" includes and indicating whose perception is authoritative in asserting conflict?	See RFP Section 6.2.C. and Attachment 4.

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153	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP	Can you clarify what constitutes an actual or perceived conflict of interest, especially regarding affiliations with LHCSAs or MCOs?	See RFP Section 6.2.C. and Attachment 4.
154	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP	This language was not included in the law. What was the Department's reasoning for adding it to the RFP?	The Department included this language to provide an example of an actual or perceived conflict that could arise in this context.
155	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP	Why does the Department now consider it a conflict for LHCSAs to provide FI services after decades of successful service provision? Should this standard then apply to all health service agencies that offer multiple services under one roof?	See answers to Questions #153 and #154. This question is not relevant to the development of a proposal under this RFP.
156	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP	Sections 4.5d and 6.2C refer to the avoidance of "actual or perceived conflicts of interest." Similarly, Attachment 4, para. 2, refers to "any conflict of interest, or perception thereof." As an LHCSA, if we are awarded the fiscal intermediary contract, we can take measures to ensure that there will be no actual or potential conflict of interest. However, the terms "perceived" and "perception" are vague and ambiguous, without any explanation of how they will be applied, e.g., perceived by whom; perceived for a valid reason?; perceived before consideration of mitigation?; perceived despite demonstrably no actual conflict? To avoid the possibility of an unfair and arbitrary result, we request that the terms "perceived" and "perception" be replaced by the term "potential." See, in this regard, the concluding sentence of Attachment 4.	The bidder will be expected to consult with its counsel and advisors.
157	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP	Section 4.5d) states that an actual or perceived conflict may include: "An entity that is owned or controlled by a Licensed Home Care Services Agency (LHCSA) or a Managed Care Organization (MCO) in New York State or that owns or holds the controlling interest in a LHCSA or MCO in New York State;" Please confirm that DOH will consider a mitigation approach that will eliminate any conflicts between the provisions of LHCSA and fiscal intermediary services.	See RFP Section 6.2.C. and Attachment 4.
158	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	Section 4.5 (d) of the RFP contains the following language: "Actual or perceived conflicts may include but are not limited to an entity that is owned or controlled by a Licensed Home Care Services Agency (LHCSA) or a Managed Care Organization (MCO) in New York State or that owns or holds the controlling interest in a LHCSA or MCO in New York State." Will the Department provide language defining what a "perceived conflict" includes and indicating whose perception is authoritative in asserting conflict?	A LHCSA licensed by the NYS Department of Health is not an eligible bidder. A managed care organization contracted to do business in NYS is not an eligible bidder.
159	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	Section 4.5 (d) What constitutes a "perceived conflict"? Who determines this? Is a Licensed Home Care Services Agency (LHCSA) considered an actual or perceived conflict of interest? Would this disqualify LHCSA organizations from winning the bid? Additionally, does this apply to entities named as subcontractors?	See answer to Question #154.
160	Conflict of Interest	Section 5.13: Vendor Assurance of No Conflict of Interest or Detrimental Effect (Page 17 of RFP)	Under 42 CFR Part 438, which outlines requirements for managed care organizations, and 42 CFR Part 441, which addresses requirements for home and community-based services, including conflict of interest standards for care managers and service coordinators, does the conflict of interest only pertain to a Licensed Home Care Services Agency (LHCSA) providing service coordination services under a 1915(c) waiver, as mentioned in Section 5.13 of the RFP?	No. See RFP Section 4.5.d).
161	Conflict of Interest	Section 6.2.C: Vendor Assurance of No Conflict of Interest or Detrimental Effect (Pages 20-21)	If an applicant owns or holds a controlling interest in a NYS LHCSA or MCO, please describe appropriate firewalls that could be implemented to address, mitigate or eliminate a perceived conflict of interest.	See RFP Section 6.2.C. and Attachment 4.
162	Conflict of Interest	Section 6.2.C: Vendor Assurance of No Conflict of Interest or Detrimental Effect (Pages 20-21)	If a bidder is a LHSCA, or related to a LHCSA per section 4.5(d) above, must the bidder disclose that even though there is no actual conflict, and the bidder perceives no conflict, and the RFP does not state that such relationship is a conflict?	Yes, the bidder must disclose all possible conflicts of interest in their proposal.
163	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services, Bullet g) (Page 5 of RFP)	What happens if the consumer disagrees with the fiscal intermediary's determination?	Determination of service level is made by the consumer's Local Department of Social Services or managed care plan. Any disagreements would be brought to their attention, not the Statewide Fiscal Intermediary.

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164	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services, Bullet g) (Page 5 of RFP)	What happens if the authorizing entity disagrees with the fiscal intermediary's determination?	See answer to Question #163
165	Consumer Responsibilities	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Is the consumer responsible for timely approving and attesting the accuracy of personal assistant time records	Yes. RFP Section 4.1 states: "Fiscal Intermediaries are not responsible for, and fiscal intermediary services shall not include fulfillment of the responsibilities of the consumer. Responsibilities of the consumer (or designated representative) include: ..... d) Timely approving and attesting to the accuracy of PA time records and transmitting such information to the FI according the FIs procedures; ....."
166	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Will the State FI be able to terminate PAs in cases of serious harm to the consumer or program, for example, if the PA is determined to have harmed or neglected a consumer or has committed Medicaid fraud?	Refer to RFP #20524 Section 4.1.g. on Page 6.
167	Consumer responsibilities	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet i) (Pages 6-7 of RFP)	Are Consumers required to maintain records?	The Department will work with the contracted Statewide Fiscal Intermediary to develop a consumer memorandum of understanding that will outline the consumer responsibilities which may include maintaining records.
168	Consumer responsibilities	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet i) (Pages 6-7 of RFP)	If Consumers are required to maintain records, must Consumers maintain records for six years?	See answer to Question #167
169	Consumer Responsibilities	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	If the consumer is currently the employer of record, can they continue to hold this status after the procurement award?	See Attachment B of the RFP.
170	Consumer responsibilities	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet a) (Page 8 of RFP)	Will the selected FI be expected to serve an otherwise eligible consumer that cannot, does not, or refuses to comply with program requirements?	Refer to RFP #20524 Section 4.1.g.
171	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services, Bullet g) (Page 5 of RFP)	What activities are required to monitor the consumer's (or if applicable, the consumer's designated representative's) continuing ability to fulfill the consumer's responsibilities under CDPAP?	Refer to RFP #20524 Section 4.1.g.
172	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services, Bullet i) (Page 5 of RFP)	Is there a "Department approved memoranda of understanding with Consumers"? Will a copy be provided to prospective bidders?	No, there is not currently a Department approved memorandum of understanding for fiscal intermediaries and consumers.
173	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	RFP Section 4:1 Page 6 top: Paragraphs: Fiscal Intermediaries are not responsible for, and fiscal intermediary services shall not include fulfillment of the responsibilities of the consumer. Responsibilities of the consumer (or designated representative) include: a) Managing their own plan of care including recruiting and hiring PAs; b) Training, scheduling and supervising PAs including arranging and scheduling substitute coverage when a PA is temporarily unavailable for any reason; c) Assuring PAs competently and safely perform the required services; d) Timely approving and attesting to the accuracy of PA time records and transmitting such information to the FI according to the FIs procedures; e) Timely notifying the FI of changes in employment status of any PA; f) Timely distributing PAs' employment checks, if physical check distribution by the Consumer to the PA is the means of payment the Consumer and PA agree upon; and g) Terminating PAs". The RFP as well as 18 NYCRR § 505.28 does not provide clarification as to the process the Statewide FI is to follow should a Designated Representative suddenly not be able to fulfill their responsibilities (those of the consumer) suddenly such as if the Designated Representative were to be hospitalized, go on vacation, or expire. Please clarify what process the FI should follow. Is there any regulation/policy stating that a Designated Representative needs to live in New York State?	A designated representative must be able to fulfill all responsibilities as outlined in 18 NYCRR 505.28 including being in attendance at all required assessments with the consumer.

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174	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	9. Section 4.1 Required Fiscal Intermediary Services, states: "Fiscal Intermediaries are not responsible for, and fiscal intermediary services shall not include fulfillment of the responsibilities of the consumer. Responsibilities of the consumer (or designated representative) include:... f) Timely distributing PA's employment checks, if physical check distribution by the Consumer to the PA is the means of payment the Consumer and PA agree upon;" While Section 4.3 4.3 Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, states: "In the delivery of the services described in Section 4.1, the Awarded Statewide FI, on its behalf and on behalf of the consumers it serves, is responsible for: a) Ensuring full and timely payment of wages established by the awarded Statewide FI, per applicable labor laws, preferably by direct deposit, and providing all statements and maintaining all records required by the New York State Labor Law…" This seems contradictory. Please explain how both requirements are able to be met?	If a paper check is requested, the Statewide Fiscal Intermediary should work with the consumer to ensure it is paid and able to be distributed in a timely manner.
175	Consumer responsibilities	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	What liability does the Statewide FI or their subcontractors bear for the timely payment of wages if the consumer is distributing paychecks? What happens if the consumer fails to fulfill this responsibility?	See answer to Question #174
176	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services, Bullet g) (Page 5 of RFP)	Monitoring the consumer's (or if applicable, the consumer's designated representative's) continuing ability to fulfill the consumer's responsibilities under CDPAP and promptly notifying the authorizing entity (i.e., the LDSS or MCO) of any circumstance that may affect the consumer's (or if applicable, the consumer's designated representative's) ability to fulfill those responsibilities;County requirements for FI services varies such as requiring in-home consumer visits at least every 90 days in Monroe County to other counties simply stating "monitoring." Please provide clarification as to the action the FI must take to monitor the consumers, or if applicable, the consumer's designated representative's continuing ability to fulfill consumer responsibilities. Also, what is the documentation requirement of the FI to substantiate that they are monitoring?	A memorandum of understanding will include the fiscal intermediary, consumer and designated representative responsibilities and the ramifications if these responsibilities are not adhered to.
177	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services, Bullet g) (Page 5 of RFP)	What criteria or factors will be considered in the "monitoring" of consumer's ability to self direct?	Refer to RFP #20524 Section 4.1.g.
178	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	What, if any, role does the fiscal intermediary have in protecting against fraud, waste, and abuse in the Medicaid program, including fraud, waste, and abuse by the consumer and/or PA? Since such role is not elucidated in the responsibilities of the fiscal intermediary, how does it take steps to protect against fraud, waste, and abuse without impinging on the responsibilities and roles of the consumer?	Refer to RFP #20524 Section 4.1.g. This would include referring any suspicions of fraud to the appropriate entities.
179	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services, Bullet g) (Page 5 of RFP)	How will the consumer be notified that the are being monitored?	A memorandum of understanding will include the fiscal intermediary, consumer and designated representative responsibilities and the ramifications if these responsibilities are not adhered to.
180	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services, Bullet g) (Page 5 of RFP)	What are the procedures of the monitoring?	Refer to RFP #20524 Section 4.1.g.
181	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services, Bullet i) (Page 5 of RFP)	What will be included in the memorandum of understanding with the consumer?	A memorandum of understanding will include the fiscal intermediary, consumer and designated representative responsibilities and the ramifications if these responsibilities are not adhered to.
182	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services, Bullet i) (Page 5 of RFP)	Does the consumer have any opportunity to amend or propose new terms to the agreement?	No.

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183	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	What specific support will be provided by the Department to ensure consumers understand and fulfill their responsibilities under the Consumer Directed Personal Assistance Program (CDPAP), as outlined in Section 4.1 of the RFP?	The Statewide Fiscal Intermediary and the consumer's LDSS or managed care plan would be responsible for ensuring consumers understand and fulfill their responsibilities under CDPAP.
184	Consumer responsibilities	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet a) (Pages 6-7 of RFP)	Can an FI, the consumer and the PA enter into a unique agreement that serves the consumer and PA's best interests? Will there be flexibility to serve the needs of individual consumers?	A memorandum of understanding will include the fiscal intermediary, consumer and designated representative responsibilities and the ramifications if these responsibilities are not adhered to.
185	Consumer responsibilities	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	What obligation does the Statewide FI or any subcontractor have to maintain a consumer on their caseload if the consumer is not able to manage their services? Particularly in light of the refusal of traditional home care agencies to open new cases, how will the state ensure the consumer's ability to continue living in the Most Integrated Setting as required by the Olmstead decision if they cannot continue to get services through the Statewide FI?	Refer to RFP #20524 Section 4.1.g.
186	Consumer Responsibilities	General	Do the members under the CDPAP have any choice in who they want to receive services from? Or is that all delegated under the single FI?	Consumers enrolled in CDPAP will still be able, and are required to, interview, hire, schedule and terminate their personal assistants.
187	Contracting	General	Is the SFI subject to requirements under 18 NYCRR 504.9 as a Service Bureau?	The Statewide Fiscal Intermediary is required to enroll as a New York State Medicaid provider.
188	Contracting	Section 1.0: Calendar of Events (Page 3 of RFP)	If a Consumer requests a Fair Hearing, will the selected FI be responsible for responding to that Fair Hearing request?	This question is not relevant to the development of a proposal under this RFP.
189	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	The RFP states that the contract may be terminated on 30-days written notice by the Department of Health if it is found that the FI has failed to comply with the provision of law or regulations. If the Statewide FI enters into a settlement agreement where it does not accept guilt, would the Department of Health be able to terminate the contract under these provisions?	The Department will examine any termination scenarios under the contract if and when they may arise on a case by case basis.
190	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	The RFP states that the contract may be terminated on 30-days written notice by the Department of Health if it is found that the FI has failed to comply with the provision of law or regulations. If the Statewide FI is found guilty of violating laws or regulations in another state in which it operates, would the Department of Health be able to terminate the contract under these provisions?	The Department will examine any termination scenarios under the contract if and when they may arise on a case by case basis.
191	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	The RFP states that the contract may be terminated on 30-days written notice by the Department of Health if it is found that the Statewide FI has failed to comply with provisions of laws and regulations. If the Statewide FI enters into a settlement agreement where it accepts penalties but does not accept guilt in another state in which it operates, would the Department of Health be able to terminate the contract under these provisions?	See answer to Question #190
192	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	The RFP states that the contract may be terminated on 30-days written notice by the Department of Health if it is found that the FI has failed to comply with the provision of law or regulations. Must the Statewide FI be found guilty of violating law or regulations to have its contract terminated in this manner?	See answer to Question #190
193	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	The RFP states that the contract may be terminated on 30 days written notice by the Department of Health if it is found that the Statewide FI has failed to comply with provisions of laws and regulations. Does the Statewide FI maintain Article 78 appeal rights in such a scenario?	Yes

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194	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	The RFP states that the contract may be terminated immediately upon written notice if the Department of Health determines that "the public health or safety would be imminently endangered by the continued operation or actions of the FI..." If the Statewide FIs contract is terminated under this clause, does it maintain Article 78 appeal rights?	Yes
195	Contracting	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Considering the distinct nature of New York State's regulatory environment and consumer-directed personal assistance program, what specific training or adaptation plans must an out-of-state SFI implement to meet New York's statutory and regulatory standards?	See section 4.1 of the RFP. It is incumbent upon the Bidder to explain to the Department how it plans to meet its obligations under the contract.
196	Contracting	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Given the critical role of fiscal intermediary services in facilitating consumers' roles as employers, how will the Department ensure that an out-of-state SFI has the requisite knowledge and capability to uphold New York State's high standards for consumer support and compliance, particularly in terms of legal and regulatory adherence?	See answer to Question #195
197	Contracting	Attachment 8: DOH Agreement, Appendix A, Clause P	While this RFP is not directly seeking a proposal for "Technology," this RFP may result in the purchase of technology to meet the requirements of EVV and/or cybersecurity. Would this provision apply in these instances?	Yes.
198	Contracting	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Will bidders need to be pre-qualified in the State Financial System (SFS) prior to submitting a proposal?	Yes.
199	Contracting	Section 2.2: Other Important NYS Contracting Information for Bidders (Pages 3-4 of RFP)	Can the Statewide FI renegotiate it's contract with DOH if changes are required during the contract period?	Any such changes would require the Department's approval and would require a formal amendment to the existing contract.
200	Contracting	General	Is this an annual contract that must be renewed?	No, the resulting contract is anticipated to be for a 5-year term. See Section 2.3 of the RFP.
201	Contracting	General	The terminology of the procurement contract is specific to New York state and providing within those parameters. Does this mean that services cannot extend into northern metropolitan areas such as Bergen and Hudson County or essentially what would be considered the suburbs of NYC?	Only New York State counties are covered by this procurement and resulting contract.
202	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	Could you elaborate on the specific conditions under which the Department may terminate the contract as mentioned in Section 2.3?	See Section 2.3 of the RFP and Attachment 8, New York State Department of Health Contract, Section III.
203	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	Under what specific circumstances can the agreement be terminated before the end of the five-year term?	See Section 2.3 of the RFP and Attachment 8, New York State Department of Health Contract, Section III.
204	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	The RFP states that "The awarded Statewide FI must be able to provide these services throughout the five-year contract term." What services specifically fall under "these services"?	See Section 4.0 of the RFP.
205	Contracting	General	Will the state take the responsibility to write and maintain both Consumer and Worker agreements?	The contracted statewide fiscal intermediary will be responsible for executing and maintaining consumer agreements. Such agreements will be either written or approved by the Department of Health.
206	Contracting	Section 2.2: Other Important NYS Contracting Information for Bidders (Pages 3-4 of RFP	Will the Statewide FI reserve the right to renegotiate this contract with the Department if it is determined that administrative changes are required to protect the stability of the program?	The Department reserves the right to negotiate terms of the contract that are non-material in nature with the contract awardee, within the scope of the RFP and in the best interests of New York State. Nonetheless, bidders must be fully prepared to accept all of the terms and conditions set forth in the RFP, without modification, should the Department determine that that constitutes the best interests of New York State.
207	Contracting	Attachment 8: DOH Agreement, NYSDOH Contract, Section III.G	May we add terms governing transition to a new vendor in case of termination?	The Department reserves the right to negotiate terms of the contract that are non-material in nature with the contract awardee, within the scope of the RFP and in the best interests of New York State. Nonetheless, bidders must be fully prepared to accept all of the terms and conditions set forth in the RFP, without modification, should the Department determine that that constitutes the best interests of New York State.

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208	Contracting	Attachment 8: DOH Agreement, NYSDOH Contract, Section IV	In lieu of the ELANY Affidavit, bidder requests to remove the requirement that the carrier be admitted by the New York State Department of Financial Services, as reflected in Attachment 8, Section IV., Subsection A.	The Department reserves the right to negotiate terms of the contract that are non-material in nature with the contract awardee, within the scope of the RFP and in the best interests of New York State. Nonetheless, bidders must be fully prepared to accept all of the terms and conditions set forth in the RFP, without modification, should the Department determine that that constitutes the best interests of New York State.
209	Contracting	Attachment 8: DOH Agreement, NYSDOH Contract, Section IV	Bidder requests that all policies be permitted to be written on a claims-made basis.	The Department reserves the right to negotiate terms of the contract that are non-material in nature with the contract awardee, within the scope of the RFP and in the best interests of New York State. Nonetheless, bidders must be fully prepared to accept all of the terms and conditions set forth in the RFP, without modification, should the Department determine that that constitutes the best interests of New York State.
210	Contracting	Attachment 8: DOH Agreement, NYSDOH Contract, Section IV	With respect to Attachment 8, Section IV., Subsection B.3. bidder requests that the language be updated to reflect that the broker will "endeavor" to provide notice of cancellation, material change or non-renewal with at least 30 days' notice. In addition, full copies of insurance policies are confidential and proprietary. Bidder requests that language be added to this section to note that copies of insurance policies will be provided, "so long as procedures are in place to ensure confidentiality." Moreover, Attachment 8, Section IV., Subsection B.3.b requires certificates of insurance to list any exclusions. Bidder requests to remove this requirement as insurance policies carry many exclusions, such that it would be impractical to list them all.	The Department reserves the right to negotiate terms of the contract that are non-material in nature with the contract awardee, within the scope of the RFP and in the best interests of New York State. Nonetheless, bidders must be fully prepared to accept all of the terms and conditions set forth in the RFP, without modification, should the Department determine that that constitutes the best interests of New York State.
211	Contracting	Attachment 8: DOH Agreement, NYSDOH Contract, Section IV	With respect to Attachment 8, Section IV., Subsection B.4, bidder requests to remove the reference to "protective liability" as it is not applicable or defined.	The Department reserves the right to negotiate terms of the contract that are non-material in nature with the contract awardee, within the scope of the RFP and in the best interests of New York State. Nonetheless, bidders must be fully prepared to accept all of the terms and conditions set forth in the RFP, without modification, should the Department determine that that constitutes the best interests of New York State.
212	Contracting	Attachment 8: DOH Agreement, NYSDOH Contract, Section IV	Bidder requests removal of reference to and requirements for ISO forms. Many polices are not prepared on ISO forms to fit the unique needs of the entity seeking insurance. The specific coverage requested can be obtained on non-ISO forms, and, therefore, ISO forms are unnecessary and unduly restrictive. Accordingly, bidder requests removal of any requirement to have a specific ISO policy. For example, reference to ISO policies can be seen in Attachment 8, Section IV., Subsections B.4. and C.3.	The Department reserves the right to negotiate terms of the contract that are non-material in nature with the contract awardee, within the scope of the RFP and in the best interests of New York State. Nonetheless, bidders must be fully prepared to accept all of the terms and conditions set forth in the RFP, without modification, should the Department determine that that constitutes the best interests of New York State.
213	Contracting	Attachment 8: DOH Agreement, NYSDOH Contract, Section IV	With respect to coverage for independent contractors and subcontractors (see Attachment 8, Section IV., Subsection 3.C.b., for example), bidder requests the ability to require that those subcontractors and independent contractors secure their own insurance.	The Department reserves the right to negotiate terms of the contract that are non-material in nature with the contract awardee, within the scope of the RFP and in the best interests of New York State. Nonetheless, bidders must be fully prepared to accept all of the terms and conditions set forth in the RFP, without modification, should the Department determine that that constitutes the best interests of New York State.
214	Contracting	Attachment 8: DOH Agreement, NYSDOH Contract, Section IV	With respect to Attachment 8, Section IV., Subsection C.3., if a policy is not written on an ISO form, it may not define terms such as contractual liability or cross liability. Can DOH provide definitions so that bidder can ensure the correct insurance is in place.	The Department reserves the right to negotiate terms of the contract that are non-material in nature with the contract awardee, within the scope of the RFP and in the best interests of New York State. Nonetheless, bidders must be fully prepared to accept all of the terms and conditions set forth in the RFP, without modification, should the Department determine that that constitutes the best interests of New York State.
215	Contracting	Attachment 8: DOH Agreement, NYSDOH Contract, Section IV	Bidder requests to remove from Attachment 8, Section IV., Subsection C.3.h. the following language: "CONTRACTOR means and methods". This coverage is inapplicable to the services.	The Department reserves the right to negotiate terms of the contract that are non-material in nature with the contract awardee, within the scope of the RFP and in the best interests of New York State. Nonetheless, bidders must be fully prepared to accept all of the terms and conditions set forth in the RFP, without modification, should the Department determine that that constitutes the best interests of New York State.
216	Contracting	Attachment 8: DOH Agreement, Appendix M	With respect to Attachment 8, Appendix M, including Sections I.C. and VL, can DOH delete any reference to liquidated damages and any option for DOH to impose liquidated damages?	The Department reserves the right to negotiate terms of the contract that are non-material in nature with the contract awardee, within the scope of the RFP and in the best interests of New York State. Nonetheless, bidders must be fully prepared to accept all of the terms and conditions set forth in the RFP, without modification, should the Department determine that that constitutes the best interests of New York State.

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217	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	How long would the contract renewal term be?	There is no reference to a contract renewal within this RFP.
218	Contracting	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Will bidders need to be pre-qualified in State Financial System (SFS) before submitting applications?	Yes.
219	Contracting	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	For potential Statewide FIs with separate ownership, are there specific thresholds that must be disclosed?	Section 3.1, Minimum Qualifications, of the RFP, outlines the required qualifications to bid.
220	Contracting	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Are there specific thresholds of investor ownership of Statewide FI applicants that must be disclosed?	Section 3.1, Minimum Qualifications, of the RFP, outlines the required qualifications to bid.
221	Contracting	Section 4.0: Scope of Work (Page 5 of RFP) and Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Can you provide more detail on the specific deliverables expected for the fiscal intermediary services under Section 4.0	No. The RFP outlines the responsibilities of the contractor.
222	Contracting	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet a) (Page 8 of RFP)	Please elaborate on the process for how the awarded single statewide FI enrolls as a CDPAP-FI enrolled Medicaid provider in NYS.	Information regarding Medicaid provider enrollment in NYS can be found here: https://www.emedny.org/info/ProviderEnrollment/enrollguide.aspx#web=step1&webtab=tabstep1
223	Contracting	Attachment 8: DOH Agreement, NYSDOH Contract, Section IV	With respect to the requirements to obtain an endorsement adding the State of New York as an additional insured (see Attachment 8, Section IV., Subsection 3.C), please confirm that a blanket endorsement will be sufficient whereby bidder is permitted to name as an additional insured any party where required by written agreement.	The Department reserves the right to negotiate terms of the contract that are non-material in nature with the contract awardee, within the scope of the RFP and in the best interests of New York State. Nonetheless, bidders must be fully prepared to accept all of the terms and conditions set forth in the RFP, without modification, should the Department determine that that constitutes the best interests of New York State.
224	Contracting	Attachment 8: DOH Agreement, NYSDOH Contract, Section IX.E.5	The contract states: "This is a 'Work for Hire' Contract. The DEPARTMENT will be the sole owner of all source code and any software which is developed for use in any application software provided to the DEPARTMENT as a part of this Contract." Does the Department expect the awarded Contractor to provide any software to the Department as part of this contract?	The Department reserves the right to negotiate terms of the contract that are non-material in nature with the contract awardee, within the scope of the RFP and in the best interests of New York State. Nonetheless, bidders must be fully prepared to accept all of the terms and conditions set forth in the RFP, without modification, should the Department determine that that constitutes the best interests of New York State.
225	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	The timeline identified in Section 5.6.2 is unduly burdensome and restrictive. Bidder requests to change any reference from 10 days to 45 days. Specifically, bidder requests the following language as replacement language: "The Contractor must provide a draft LOC/Revolving Credit Agreement to the Department within forty-five (45) business days of notice from the Department of contract approval. Failure to provide the draft LOC/Revolving Credit Agreement to the Department within forty-five (45) business days of such notice will constitute grounds for termination for cause. The executed LOC/Revolving Credit Agreement must be provided to the Department within forty-five (45) business days of the Department's approval of the draft LOC/Revolving Credit Agreement."	The Department will not make the changes requested.

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226	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Bidder requests to delete the following language from Section 5.6.2, as reflected in paragraphs 2, 3 and 4: "[2]… As set forth in ii, should the Contractor fail to obtain an LOC/Revolving Line of Credit from another financial institution, the Department shall be entitled to draw the balance of the LOC/Revolving Line of Credit within one (1) business day of receipt of such notice. 3. The LOC/Revolving Credit Agreement must provide funds to the Department for any liability, loss, damage, or expense as a result of the Contractor's failure to perform fully and completely all requirements of the Contract. Such requirements include, but are not limited to, the Contractor's obligation to pay liquidated damages, indemnify the Department under circumstances described in the Contract, and the Contractor's obligation to perform the services required by the Contract throughout the entire term of the Contract. 4. The LOC/Revolving Credit Agreement shall also provide that the bank, as defined in subdivision one of section two of New York Banking Law, where the drafts are drawn must be located within New York State." These requirements are overly restrictive, unduly burdensome, and do not provide for sufficient opportunities to cure.	The Department will not remove the requested language.
227	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	The RFP requires that the successful bidder must maintain a Line of Credit of $100 million for the length of the contract, including 180 days after. How was this number arrived at, given that it is less than one-quarter of the anticipated bi-weekly payroll costs of the Awarded Statewide FI?	This question is not relevant to the development of a proposal under this RFP.
228	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Where did the Department come up with the $100 million figure for a required line of credit?	This question is not relevant to the development of a proposal under this RFP.
229	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	The RFP references a $100 million LOC. Is this to guarantee payroll coverage to the state, or is it exclusively used for payroll?	Section 5.6.2 states: "Without additional cost to the Department, and as a material condition of the Contract, the Contractor must furnish, for the duration of the contract term (including any extensions) plus one hundred eighty (180) calendar days thereafter, an irrevocable Revolving Credit Letter of Credit (LOC) or Revolving Line of Credit, for the third-party benefit of the Department in the amount of at least one hundred million U.S. Dollars ($100,000,000.00), **to be used exclusively by the Contractor to meet its obligations and responsibilities under the Contract, including but in no way limited to, ensuring that the Contractor maintains sufficient liquidity to guaranty timely and uninterrupted payment to all PAs for the duration of the contract term."** (emphasis added).
230	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Does the bidder need to provide evidence of the revolving LOC as part of the RFP submission?	Section 5.6.2 states: "The Issuer shall be subject to the approval of the Department. The form for the LOC/Revolving Credit Agreement shall be subject to the approval of the Department. The Contractor must provide a draft LOC/Revolving Credit Agreement to the Department within ten (10) business days of notice from the Department of contract approval. Failure to provide the draft LOC/Revolving Credit Agreement to the Department within ten (10) business days of such notice will constitute grounds for termination for cause."
231	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Must the Bidder attest to its ability to secure the Revolving LOC in its response to the RFP?	See answer to Question #230
232	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	What documentation is required at application submission for the Revolving Line of Credit?	See answer to Question #230
233	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	The RFP requires that the successful bidder must maintain a Line of Credit of $100 million for the length of the contract, including 180 days after at no additional cost to the state (emphasis added). Given this requirement, is the bidder allowed to incorporate this cost in the PMPM administrative payment?	No the Line of Credit is separate from the PMPM administrative cost component of the submission

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Number	Subject	Corresponding RFP Section	Question	Answer
234	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Given the substantial financial demands of managing payroll for the entire state's CDPA program, what are the minimum capital and liquidity requirements for the SFI to ensure they can meet payroll obligations without delay, particularly during the first two months of operation?	The credit requirements are dictated in RFP Section 5.6.2.
235	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Will the Department require detailed cash flow projections from SFI bidders to ensure they can manage the payroll and operational expenses for the initial 60 days, and if so, what specific metrics and assumptions should these projections include?	No. The credit requirements are dictated in RFP Section 5.6.2.
236	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	How will the Department verify the existence and adequacy of a revolving credit facility for the SFI to cover the immediate payroll needs, and what are the criteria for assessing the sufficiency of this credit facility?	This question is not relevant to the development of a proposal under this RFP.
237	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	What contingency plans are in place to prevent service disruptions and ensure continuous payment to personal assistants if the awarded SFI encounters cash flow issues within the first 30-60 days of contract implementation?	It is incumbent upon each bidder to explain to the Department how it plans to meet its obligations under the contract.
238	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	How will the Department monitor and enforce the SFI's ability to manage payroll during the transition period, especially considering the potential delay in state funding and the need to maintain uninterrupted service delivery to Medicaid beneficiaries?	This question is not relevant to the development of a proposal under this RFP.
239	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	What risk mitigation strategies will the Department implement to address potential payroll delays that could arise from the SFI's insufficient cash reserves, and how will these strategies be communicated to consumers and personal assistants?	This question is not relevant to the development of a proposal under this RFP.
240	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Will the Department conduct regular financial health evaluations of the SFI to ensure ongoing liquidity and capital adequacy throughout the contract term, and what parameters will be used for these evaluations?	This question is not relevant to the development of a proposal under this RFP.
241	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	With respect to Section 5.6.2 titled "Revolving Credit Facility", in the event that an entity already holds a line of credit that meets the monetary requirements outlined in this section, is another line of credit required in order to dedicate it exclusively to the CDPAP program? The requirements outlined in Section 5.6.2 are unduly restrictive and will likely eliminate a large number of providers.	Yes, a dedicated line of credit meeting the requirements outlined in the RFP is required.
242	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Beyond the Line of Credit/Revolving Credit Agreement requirements, are there any other capital reserve requirements of the prospective fiscal intermediary?	No.
243	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	If there are any other capital reserve requirements of the prospective fiscal intermediary, what are they?	The credit requirements are outlined in RFP Section 5.6.2.
244	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Knowing the annual contract estimate for CDPAP is over $7 billion, what specific documentation, such as audited financial statements and bank statements, will the Department require from SFI bidders or the awarded SFI to demonstrate liquidity outside of the LOC to support the program?	The credit requirements are outlined in RFP Section 5.6.2.
245	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	If the SFI's revolving credit facility proves insufficient, what mechanisms will be available to ensure personal assistants are paid on time, and how will the Department oversee the implementation of these mechanisms?	This question is not relevant to the development of a proposal under this RFP.
246	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	What reporting requirements will be imposed on the SFI to maintain transparency regarding their financial health and ability to meet payroll obligations, and how frequently will these reports be reviewed by the Department?	This question is not relevant to the development of a proposal under this RFP.
247	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Will there be changes to the revolving LOC amount?	No.
248	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Must the financial institution issuing the line of credit have its home office in New York State?	No. Section 5.6.2(4) of the RFP states: "The LOC/Revolving Credit Agreement shall also provide that the bank, as defined in subdivision one of section two of New York Banking Law, where the drafts are drawn must be located within New York State."
249	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Is the line of credit "unused" bank fees reasonable costs to include in the PMPM?	No, "unused" bank fees are not related to FI Administrative services as outlined in the RFP

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250	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Is there flexibility in the $100 million line of credit? If an agency incurs unused fees, how are cost savings justified? An agency can incur up to $750,000 (9%) per month in unused fees for a LOC of $100,000,000.	No.
251	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	The RFP states: "The Contractor must furnish an irrevocable Revolving Credit Letter of Credit (LOC) or Revolving Line of Credit for the third party benefit of the Department in the amount of at least one hundred million U.S. Dollars." Under what circumstances would the Department be able to draw on the LOC and what recourse will the bidder have?	Any lawful circumstances and any lawful recourse. Bidders should consult their legal counsel.
252	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	The RFP states: "The LOC/Revolving Credit Agreement shall be issued by or entered into with a singular financial institution ('Issuer") licensed to do business under the laws of the State of New York. The issuer shall be subject to the approval of the Department. The form for the LOC/Revolving Credit Agreement shall be subject to the approval of the Department. The Contractor must provide a draft LOC/Revolving Credit Agreement to the Department within 10 (business days of notice from the Department of contract approval." Does the applicant need to obtain the DOH's prior-approval of its choice of lender (i.e., the bank) BEFORE it provides the DOH with the "form for the LOC/Revolving Credit Agreement?"	Section 5.6.2 of the RFP states: "The Issuer shall be subject to the approval of the Department. The form for the LOC/Revolving Credit Agreement shall be subject to the approval of the Department. The Contractor must provide a draft LOC/Revolving Credit Agreement to the Department within ten (10) business days of notice from the Department of contract approval. Failure to provide the draft LOC/Revolving Credit Agreement to the Department within ten (10) business days of such notice will constitute grounds for termination for cause. The executed LOC/Revolving Credit Agreement must be provided to the Department within ten (10) business days of the Department's approval of the draft LOC/Revolving Credit Agreement. The Department reserves the right to extend the due date for the executed LOC/Revolving Credit Agreement based on circumstances the Department determines to be reasonable. Failure to provide the final LOC/Revolving Credit Agreement to the Department within the date set will constitute grounds for termination for cause."
253	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Section 5.6.2 of the RFP requires a $100 million line of credit. Must the $100 million be secured?	Yes.
254	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Is it acceptable under the contract for the $100,000,000 LOC to be issued by a "lead institution" with that institution aligning other institutions for tiers of the total?	Please see Section 5.6.2 of the RFP: "The LOC/Revolving Credit Agreement shall be issued by or entered into with **a singular financial institution** ("Issuer") licensed to do business under the laws of the State of New York. The Issuer shall be subject to the approval of the Department."
255	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	If the Revolving Credit Letter of Credit (LOC) or Revolving Line of Credit is utilized during the initial 30-60 days of operation because the Statewide FI is waiting on claims to be adjudicated, will the resulting interest payments to the bank be considered allowable direct care costs on the cost report?	This question is not relevant to the development of a bid under this RFP.
256	Cultural Competence	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Can bidders plan to subcontract with other entities who can demonstrate cultural and language competency, and disability experience to meet this criteria?	Bidders shall demonstrate in the proposal their or their subcontractors' experience and ability to engage with any consumer or personal assistant who speaks any language and in a culturally competent manner, and to engage with consumers of all physical, developmental and neurological abilities including those that are hearing or visually impaired. How this is to be accomplished is at the bidder's discretion.
257	Cultural Competence	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Can the Department clarify how it will determine "demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce" without provide Statewide FI bidders with the specific consumer and workforce composition, which will inevitably vaster than most every other state?	Documentation submitted should reflect that the Statewide Fiscal Intermediary is responsible for understanding and being aware of the cultural and linguistic needs of the consumers and personal assistants it anticipates serving.
258	Cultural Competence	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder has a "demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce with experience serving individuals with disabilities". How is the state defining "language competencies"?	See answer to Question #257
259	Cultural Competence	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder has a "demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce with experience serving individuals with disabilities". What specific languages and dialects must a qualified bidder be expected to demonstrate competencies in?	See answer to Question #257

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260	Cultural Competence	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder has a "demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce with experience serving individuals with disabilities". New York is a diverse State. Is there a base level of cultural competencies a qualified bidder is expected to meet? If so, what are they?	See answer to Question #257
261	Cultural Competence	Section 3.1: Minimum Qualifications (Page 4 of RFP)	How does the Department define cultural and language competencies?	See answer to Question #257
262	Cultural Competence	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder has "demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce with experience services individuals with disabilities..." Will the Department of Health be providing bidders with information about the cultural and language competencies necessary to meet the needs of the consumers and available workforce? Put another way, will the Department inform bidders of what cultures and languages they are expected to be able to demonstrate competency with?	See answer to Question #257
263	Cultural Competence	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder has "demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce with experience serving individuals with disabilities..." Do bidders have to demonstration experience serving individuals with all types of disabilities, including, but not limited to, developmental, neurological, and physical?	See answer to Question #257
264	Cultural Competence	Section 3.1: Minimum Qualifications (Page 4 of RFP)	What is considered experience serving individuals with disabilities?	See answer to Question #257
265	Cultural Competence	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Does the bidder for the Statewide FI contract have to have demonstrated experience in serving people with disabilities in the capacity of meeting their specific needs or incidental experience with people with disabilities?	See answer to Question #257
266	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Considering New York State's unparalleled diversity in cultural and language competencies, how does the Department expect an SFI that only performs fiscal intermediary services in another state to adequately demonstrate the required cultural and language competencies specific to New York's population and workforce?	See answer to Question #257
267	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What cultures are specific to the population of consumers?	See answer to Question #257
268	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What cultures are specific to the available workforce?	See answer to Question #257
269	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What cultural competences specific to the population of consumers must a bidder demonstrate?	See answer to Question #257
270	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What cultural competences specific to the population of the available workforce must a bidder demonstrate?	See answer to Question #257
271	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What language competences specific to the population of the available workforce must a bidder demonstrate?	See answer to Question #257
272	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What information is available regarding the cultural needs of the population of consumers?	See answer to Question #257
273	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What information is available regarding the cultural needs of the available workforce?	See answer to Question #257

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274	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Does the bidder need to demonstrate cultural or language competency in the provision of services in at least one other state?	See answer to Question #257
275	Cultural Competence	Section 3.1: Minimum Qualifications (Page 4 of RFP)	This section of the RFP states that the single FI must be providing services on a statewide basis in another state. There is a rich culture of diversity across New York State. How does providing statewide services in another state align with demonstrating cultural and language competencies specific to the population of consumers in New York State?	See answer to Question #257
276	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP) and Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	Can you provide examples of how cultural and linguistic competencies should be demonstrated for the diverse populations mentioned?	See answer to Question #257
277	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What experience would a Single FI need in order to demonstrate cultural and language competencies?	See answer to Question #257
278	Cultural Competence	Section 4.0: Scope of Work (Page 5 of RFP)	What criteria define whether a NYS DOH MLTC rate setting region subcontractor has “a proven record of delivering services to individuals with disabilities”?	See answer to Question #257
279	Cultural Competence	Section 4.0: Scope of Work (Page 5 of RFP)	What criteria define whether a NYS DOH MLTC rate setting region subcontractor has “a proven record of delivering services to . . . the senior population”?	See answer to Question #257
280	Cultural Competence	Section 4.0: Scope of Work (Page 5 of RFP)	Who determines whether a subcontractor “has a proven record of delivering services to individuals with disabilities and the senior population”?	See answer to Question #257
281	Cultural Competence	Section 4.0: Scope of Work (Page 5 of RFP)	What criteria define whether a NYS DOH MLTC rate setting region subcontractor has “a proven record of delivering services to individuals with disabilities”?	See answer to Question #257
282	Cultural Competence	Section 4.0: Scope of Work (Page 5 of RFP)	What criteria define whether a NYS DOH MLTC rate setting region subcontractor has “a proven record of delivering services to . . . the senior population”?	See answer to Question #257
283	Cultural Competence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet e) (Page 8 of RFP)	Will sufficient linguistic and cultural services include meeting the needs of the deaf community?	See answer to Question #257
284	Cultural Competence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet e) (Page 8 of RFP)	Will sufficient linguistic and cultural services include meeting the needs of the blind and visually impaired?	See answer to Question #257
285	Cultural Competence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet e) (Page 8 of RFP)	What specific cultural and linguistic competencies will the statewide fiscal intermediary be required to ensure?	See answer to Question #257
286	Cultural Competence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet e) (Page 8 of RFP)	Can the Department provide a definition of “appropriate cultural and linguistic competencies”? What specific expectations does this requirement entail?	See answer to Question #257
287	Cultural Competence	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	The RFP states that the awarded Statewide FI must "Ensure that it has the appropriate cultural and linguistic competencies to serve consumers and those of the available PAs that assist consumers." Please define what qualifies as "appropriate cultural and linguistic competencies".	See answer to Question #257
288	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Regarding the term "shall" in the eligibility criteria, how does the Department plan to verify and enforce compliance with the requirement for bidders to have demonstrated cultural and language competencies and experience serving individuals with disabilities, particularly when such competencies may vary widely across different states and populations?	See answer to Question #257
289	Cultural Competence	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	Will overseas or offshore subcontractors be allowed to ensure the cultural and language competencies of the bidder's staff and subcontractors, as outlined in Section 4.5 of the RFP?	All Data shall remain in the Continental United States (CONUS). Any Data stored, or acted upon, must be located solely in Data Centers in CONUS. Services which directly or indirectly access Data may only be performed from locations within CONUS.

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290	Cultural Competence	Section 4.0: Scope of Work, Third Bullet (Page 5 of RFP)	Does the requirement of having a proven track record of delivering services to individuals with disabilities and the senior population only apply to the CDPAP program, or can it have been provided through other programs?	Bidders must be able to fulfill the fiscal intermediary requirements as outlined in RFP Section 4.
291	Cultural Competence	General	How does the Department intend to ensure cultural competence across the extensive, highly regionalized and diverse populations of New York?	This is a minimum qualification of a bidder under this RFP. The Department cannot speak to this until there is an awardee. Bidders should follow the instructions included throughout Section 6 and any applicable attachments when responding.
292	Cultural Competence	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Can the Department clarify how it will evaluate “demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce” for Statewide FI bidders without the Department providing specific information in relation to the CDPAP consumer and workforce composition? Given the unique and diverse demographics of New York State, which are significantly more varied than most other states, will the Department provide specific data on the consumer and workforce composition that bidders must address?	See answer to Question #291
293	Cultural Competence	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder has "demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce with experience serving individuals with disabilities..." What metric(s) will be used to assess cultural competencies?	See answer to Question #291
294	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	This section specifies the requirement that the awarded Statewide FI must be capable of providing "statewide fiscal intermediary services with "demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce. New York remains one of the most ethnically, socioeconomically, and culturally diverse states in the nation. How will competence to meet this service requirement be evaluated by the Department, given that comparison to service provision in other states is not a sufficient analogue?	See answer to Question #291
295	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What specific criteria and evaluation methods will the Department use to assess an SFI’s cultural and language competencies to ensure they meet the diverse needs of New York State's population if the SFI does not currently operate within New York?	See answer to Question #291
296	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	How will the Department verify the claimed cultural and language competencies of an out-of-state SFI, and what documentation will be required to substantiate these claims?	See answer to Question #291
297	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What criteria will be used to evaluate whether an entity can demonstrate cultural and language competencies specific to the population of consumers and those of the available workforce with experience serving individuals with disabilities?	See answer to Question #291
298	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Will the Department evaluate and score the bidders plan to address cultural and language competencies to ensure they remain relevant and effective the course of the entire contract award period?	See answer to Question #291
299	Cultural Competence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet e) (Page 8 of RFP)	How will cultural and linguistic competencies be evaluated by the Department? What specific benchmarks or metrics will be used in this evaluation?	See answer to Question #291
300	Cultural Competence	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	Under 4.5 e, how are you going to measure whether a bidder meets this requirement?	See answer to Question #291
301	Cultural Competence	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	What criteria will be used to assess the cultural and language competencies of the bidder's staff and subcontractors, as outlined in Section 4.5 of the RFP?	See answer to Question #291
302	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What type of experiences does a Single FI applicant need to show to reflect cultural and language competencies? How will this be evaluated?	See answers to Questions #291 and #257

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303	Cultural Competence	Section 3.1: Minimum Qualifications (Page 4 of RFP)	How will the Department ensure that the chosen Statewide FI can effectively meet the diverse cultural and linguistic needs across all regions of New York State, including those with unique or less common language requirements? Additionally, what metrics and criteria will be used to assess and verify the cultural and language competencies of bidders to ensure they can provide equitable and effective services statewide?	See answer to Question #291
304	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	If an out-of-state SFI is awarded the contract, what specific measures and timelines will be mandated to ensure the SFI rapidly acquires and demonstrates the necessary cultural and language competencies for New York State?	See answer to Question #291
305	Cultural Competence	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	How does the Department plan to verify and enforce compliance with the requirement for bidders to have demonstrated cultural and language competencies on a "statewide basis" and experience serving individuals with disabilities?	See answer to Question #291
306	Cultural Competence	Section 4.0: Scope of Work, Paragraph 1 (Page 5 of RFP)	Given the broad and diverse needs of consumers across New York State, how does the Department plan to ensure that the single Statewide Fiscal Intermediary can adequately meet the distinct needs of each region, particularly in terms of cultural and linguistic competencies?	See answer to Question #291
307	Cultural Competence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet e) (Page 8 of RFP)	How does DOH intend to oversee the compliance with the requirement to provide services sufficient linguistic and cultural understanding?	See answer to Question #291
308	Cultural Competence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet e) (Page 8 of RFP)	The RFP mentions the importance of cultural and linguistic competencies. How does the Department plan to ensure that a single FI can adequately meet the diverse needs of consumers across different regions, languages, and cultural backgrounds without compromising service quality?	See answer to Question #291
309	Cultural Competence	Section 6.2.F.1: Required Fiscal Intermediary Scope of Work (Pages 22-23 of RFP)	The RFP states that the bidder must describe its ability to "provide cultural and linguistic competencies that reflect the needs of the consumers they propose to serve." The Department did not provide a breakdown of the linguistic or cultural populations currently served by the program, as they did for the total number of consumers by region. Given that the bidder must accept all consumers, please provide a breakdown of the languages and cultures the bidders are expected to serve.	The Department does not have this information.
310	Eligibility	Section 3.0: Bidders Qualifications (Page 4 of RFP)	Should the FI meet the minimum requirements of Section 3.1, but it is only able to secure the funding described in Section 5.6.2 through a parent company, would the FI be selected for award?	The letter of credit obtained by the awardee must meet all the requirements as outlined in RFP Section 5.6.2.
311	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Should the FI meet the minimum requirements of Section 3.1, but it is only able to secure the funding described in Section 5.6.2 through venture capital funding, would the FI be selected for award?	The letter of credit obtained by the awardee must meet all the requirements as outlined in RFP Section 5.6.2.
312	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Given the critical nature of the minimum qualifications and the use of "shall," can the Department explain how it will handle bids from entities that may meet some but not all of the specified criteria? Is there any flexibility for entities that demonstrate exceptional capabilities in other areas but may not fully meet the "statewide basis" requirement?	Bidders must meet minimum eligibility requirements for their proposal to advance to the evaluation process. The evaluation process will determine the best value proposal to be awarded.
313	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Does the state have a list of entities that are providing services as a fiscal intermediary on a statewide basis in at least one other state? Please post that list if it is available.	No
314	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Must a bidder be a fiscal intermediary in New York State as of April 1, 2024?	No
315	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Must a bidder be a statewide fiscal intermediary in New York State as of April 1, 2024?	No

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316	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Can the Department provide examples or case studies of entities that would meet the "statewide basis" requirement to offer clearer guidance to potential bidders and ensure that all applicants have a uniform understanding of the eligibility criteria?	No.
317	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Can the Department provide examples or case studies where an SFI operating solely outside of New York State successfully demonstrated cultural and language competencies equivalent to those required in New York?	No.
318	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Has the Department of Health made a determination of which prospective bidders meet the qualification requirements regarding prior fiscal intermediary services in another state?	No.
319	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Does the "other state" in which the fiscal intermediary is operating required to have as many consumers as New York State has at the time of the issuance of the RFP?	No.
320	Eligibility	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	Has the Department made a determination of likely bidders?	No.
321	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	A minimum qualification requires that the bidder, "as of April 1st, 2024, is providing services as a fiscal intermediary on a statewide basis in at least one other state." In place of this minimum requirement, would the Department be open to FIs who have vast experience within NYS? If not, why is having experience in another state more valuable? Must the new single statewide FI also have experience providing similar services in NYS?	The required experience for bidders is outlined in the RFP.
322	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Bullet a) states, "An entity capable of performing statewide fiscal intermediary services with demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce with experience serving individuals with disabilities **and as of April 1st, 2024, is providing services as a fiscal intermediary on a statewide basis in at least one other state. "** Our organization has been a Fiscal Intermediary since 2001 in NYS. Do we meet this minimum qualification to submit a bid?	No. The requirement to be met is that the organization has been a statewide FI in at least one state other than New York.
323	Eligibility	General	Can you further define and clarify a statewide FI?	See Amendment #3 to the RFP.
324	Eligibility	Section 4.0: Scope of Work, Third Bullet (Page 5 of RFP)	Section 4.0 bullet three states, "…with at least one entity…"; Attachment B checkbox three states, "…with an entity…". Was the different wording unintentional? If it was not, which one is accurate? If so, can you please explain the difference?	See Amendment #3 to the RFP.
325	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP) and Attachment B (Pages 29-30 of RFP)	What is the difference between the Single Statewide FI providing services "In" another state and "With" another state? Please clarify In vs With.	See Amendment #3 to the RFP.
326	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder must be "capable of performing statewide fiscal intermediary services..." Does this mean that the bidder must be capable of performing fiscal intermediary services as defined in Social Services Law 365-f(4-a)(ii)(A-J) and 18 NYCRR 505.28(i)(1)?	The bidder must be capable of performing all tasks as outlined in the RFP.
327	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Does the qualification "providing services as a fiscal intermediary on a statewide basis in at least one other state" mean operating in one (1) state outside New York State or more than one (1) state?	See Amendment #3 to the RFP.

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328	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	The RFP uses the term "shall" in the sentence "Entities eligible to submit a bid under this RFP in accordance with SSL § 365-f shall include: a) An entity capable of performing statewide fiscal intermediary services with demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce with experience serving individuals with disabilities and as of April 1st, 2024, is providing services as a fiscal intermediary on a statewide basis in at least one other state." Can the Department clarify if the word "shall" implies that only entities meeting these exact criteria are eligible to submit a bid, or if there is flexibility in interpreting these qualifications that opens up bid submissions to entities that do not meeting the qualification in (a)?	The terms "shall", "will" and "must" are used interchangeably for the purposes of this RFP.
329	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	How will the Department address potential disputes or challenges regarding the interpretation of "shall" and the criteria outlined in the minimum qualifications, especially concerning the term "statewide basis" and the level of cultural and language competencies required?	See Amendment #3 to the RFP.
330	Eligibility	General	Is the Department able to share whether it received interest from several potential bidders through the Questions submission to help ensure a competitive bidding process for this new contract?	This information will not be shared with the bidding community.
331	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Can the Department clarify whether a qualified SFI bidder must currently perform fiscal intermediary services in both New York State and at least one other state to be eligible, or if an entity that only performs these services in a state other than New York could still qualify for the SFI contract?	See Amendment #3 to the RFP.
332	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder must be "providing services as a fiscal intermediary on a statewide basis in another state." If the bidder is providing services similar to those offered by a fiscal intermediary, but is not called a fiscal intermediary in that state, is the entity capable of bidding?	Yes. RFP Section 3.1 (a) states: "An entity capable of performing statewide fiscal intermediary services with demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce with experience serving individuals with disabilities and as of April 1st, 2024, is providing services as a fiscal intermediary on a statewide basis in at least one other state.". If an entity is providing services as a fiscal intermediary on a statewide basis (as defined in the Amendment #3 to the RFP) in at least one other state, and is performing services similar to those required under Social Services Law 365-f, that entity would meet the subject minimum qualification requirement regardless of the formal title given to the fiscal intermediary in that state.
333	Eligibility	Section 8.1: General Information (Pages 25-26 of RFP)	Will non-awarded applicants remain eligible as potential subcontractors under the awarded Statewide FI (assuming they meet all applicable subcontractor eligibility criteria)?	Yes.
334	Eligibility	General	Does the agency who applied for RFP# 20524 must be a licensed Home Health Care Agency, or Certified Home Health Care Agency?	No.
335	Eligibility	General	Does the agency who applied for RFP#20524 must have subcontract agency?	Yes. See RFP Section 4.0.
336	Eligibility	General	Does the agency who applied for RFP#20524 must have an office in another state also in operating of CDPAP program?	See RFP Section 4.5.g
337	Eligibility	Section 2.1: Background Information (Page 3 of RFP)	The RFP states that fiscal intermediaries are "entities that perform administrative and financial functions for consumer within CDPAP, which may include assisting consumers with navigation of the program by providing individual consumer assistance and support as needed, consumer peer support, and education and training to consumers on their duties under the program." Is this the controlling definition of fiscal intermediary for the purposes of this RFP?	The Statewide Fiscal Intermediary must be able to meet all required responsibilities as outlined in the RFP through their own organization or that of a subcontractor.
338	Eligibility	Section 2.1: Background Information (Page 3 of RFP)	"Fiscal Intermediaries" is undefined in the RFP document. Other states refer to the agency that performs similar functions in a Consumer-Directed personal care program as an "Intermediary Service Organization" (ISO). Is this an interchangeable term for purposes of the RFP?	See response to Question #332.

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339	Eligibility	Section 3.0: Bidders Qualifications (Page 4 of RFP)	In order to achieve a successful transition to a single FI in NY, it is critical that bidders not only have experience serving members statewide, but also bring experience with a direct contract with a State. To qualify as the single FI do bidders need to have a contract directly with another state?	See Amendment #3 to the RFP.
340	Eligibility	Section 3.0: Bidders Qualifications (Page 4 of RFP)	Please confirm that an entity who operates a statewide FI in another state is permitted to form a new, affiliated company to be the RFP applicant in NY. This may be necessary for corporate, financing, tax, insurance and other reasons	Bidders should consult your counsel regarding corporate structuring.
341	Eligibility	Section 3.0: Bidders Qualifications (Page 4 of RFP)	Under this New York law, the Fiscal Intermediary vendor must "have been established as a fiscal intermediary prior to January 1, 2012 *and have been continuously providing such services for eligible individuals* …" however, Section 3.1 of the RFP omits the italicized language requiring continuous services. How does the Department justify such language in Section 3.1 of the RFP?	Please refer to Social Services Law Section 365-f.
342	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Can the Department clarify how it will determine statewide experience, specifically the criteria for what constitutes "statewide experience" in at least one other state? Specifically, does this experience require (1) having the exclusive statewide contract in that state, as opposed to sharing the contract with multiple entities, and (2) having a statewide contract but lacking significant consumer enrollment or service experience in various geographic regions due to other entities holding concurrent statewide contracts and thus serving specific regions? How does the Department define and measure "statewide experience" to ensure the chosen entity has comprehensive service capabilities across the entire state?	See Amendment #3 to the RFP.
343	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	How will a Statewide FI applicant/bidder's minimum qualification and/or experience be impacted if it has only experience performing fiscal intermediary services using the fiscal/employer agent and employer choice model, which is contrary to New York State's agency with choice and hours authorized model?	See Amendment #3 to the RFP.
344	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Are there any corporate requirements as to how the FI entity must be organized (not-for-profit; for-profit; owned by private equity)?	No.
345	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	We are licensed in the state of New York but have agencies in other states as well under different types of licenses. Will this affect eligibility?	No, provided the entities in other states meet the minimum qualifications.
346	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The term "fiscal intermediary" is a term of art particular to New York law. What criteria or definition is DOH using in determining whether a provider is providing services "as a fiscal intermediary" in another state?	See Amendment #3 to the RFP.
347	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Is an affiliate of a LHCSA eligible to apply (see 4.5(d))?	See section 3.1 of the RFP.
348	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	How is the term "statewide basis" defined? What criteria or definition is DOH using in determining whether a provider is, as of April 1, 2024, providing services as a fiscal intermediary "on a statewide basis" in another state?	See Amendment #3 to the RFP.
349	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	What factors, if any, will the Department consider when determining whether a bidder is "capable of providing statewide intermediary services"? Are bidders required to currently provide services in every county (or some other unit of geographic measurement)? Or is having the means to provide such services in every county (or some other unit of geographic measurement) sufficient? Is there a minimum level of service required in each locality?	See Amendment #3 to the RFP.
350	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	In order to be an eligible bidder, must an entity have a contract for FI services with another state, or will an FI that is providing services that geographically cover such state qualify?	See Amendment #3 to the RFP.
351	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder must, as of April 1, 2024, serve as an FI on a "statewide basis in at least one other state". Does "statewide basis" mean serving as the only FI in another state?	See Amendment #3 to the RFP.

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352	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Section 3.1, titled "Minimal Qualifications," states: "An entity capable of performing statewide fiscal intermediary services with demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce, with experience serving individuals with disabilities, and as of April 1st, 2024, is providing services as a fiscal intermediary on a statewide basis in at least one other state." If we are not currently servicing in other states, should/can we still submit the RFP? If we choose not to submit, will we still be able to provide CDPAP services?	See Amendment #3 to the RFP. If an organization does not meet the minimum qualifications, any proposal submitted will not be evaluated.
353	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder must, as of April 1, 2024, serve as an FI on a "statewide basis in at least one other state". Does "statewide basis" mean being available to serve as an FI or actually providing FI services in every region of the State?	See Amendment #3 to the RFP.
354	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Which services does a bidder need to provide in another state as an FI for the purposes of eligibility? Is providing EVV services that maintains time records and other wage and benefit processing documentation, as required under 4.1(e) of the RFP, on a statewide basis sufficient to meet the second prong of the minimum qualifications under section 3.1(a) of the RFP (i.e., "as of April 1st, 2024, is providing services as a fiscal intermediary on a statewide basis in at least one other state.")?	See Amendment #3 to the RFP.
355	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder must be "providing services as a fiscal intermediary on a statewide basis in another state." Is there a threshold level of fiscal intermediary services a bidder must be providing on a statewide basis in another state to qualify them for bidding in New York? That is, is there a minimum portion of overlap between what other states identify as the role of a fiscal intermediary and what New York identifies as the role of a fiscal intermediary to qualify an entity to bid as a fiscal intermediary?	See Amendment #3 to the RFP.
356	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Does a bidder need to have prior experience as a fiscal intermediary in New York State to demonstrate that is capable of performing statewide fiscal intermediary services?	No.
357	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Does a bidder need to have prior experience providing fiscal intermediary services in the Consumer Directed Personal Assistance Program to demonstrate that it is capable of performing statewide fiscal intermediary services?	See Amendment #3 to the RFP.
358	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Does a bidder need to demonstrate specific geographical footprint measurement, or percentage of state Consumers served as of a certain date or time period?	See Amendment #3 to the RFP.
359	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What criteria will be used to evaluate whether an entity is providing services as a fiscal intermediary on a statewide basis in at least one other state?	See Amendment #3 to the RFP.
360	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	This section says "is providing services as a fiscal intermediary on a statewide basis in at least one other state." The statute and Attachment B state, "with at least one other state." Is there a different meaning between the two? What is the meaning?	See Amendment #3 to the RFP.
361	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What is the definition of "providing services as a fiscal intermediary . . . in at least one other state"?	See Amendment #3 to the RFP.
362	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What is the definition of "on a statewide basis"?	See Amendment #3 to the RFP.
363	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	How will the Department determine whether a bidder is providing fiscal intermediary services in at least one other state?	See Amendment #3 to the RFP.

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364	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Does the particular state in which the fiscal intermediary currently provides services matter?	No.
365	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What population(s) must the bidder serve in another state to qualify as having providing services as a fiscal intermediary in at least one other state?	See Amendment #3 to the RFP.
366	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Given the various types of consumer-directed services (e.g., for people with developmental disabilities, people with physical disabilities, older adults, veterans), does the population that the fiscal intermediary has previously served matter?	See Amendment #3 to the RFP.
367	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Given state variation in terminology, do the services in another state need to be called "fiscal intermediary" services or are there are terms that are the equivalent of "fiscal intermediary" services that will be acceptable?	See Amendment #3 to the RFP.
368	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Must the services delivered in another state match the definition of fiscal intermediary services set forth in Social Services Law section 365-f(4-a)(a)?	See Amendment #3 to the RFP.
369	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Does the bidder need to demonstrate it is in good standing in at least one other state in providing fiscal intermediary services?	This will be examined as part of the Vendor Responsibility Questionnaire review.
370	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Does the bidder need to provide information regarding its provision of fiscal intermediary services in another state, including survey and/or fiscal data?	See RFP Section 6.2.D and Attachment B.
371	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	"An entity capable of performing statewide fiscal intermediary services .. is providing services as a fiscal intermediary on a statewide basis in at least one other state." Does this mean that a FI must be the only approved FI in another state awarded the contract? If that is the case, will the state publish the specific list of bidders (or number of those bidders) who are authorized to submit bids?	See Amendment #3 to the RFP. The Department does not have a list of potential bidders.
372	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Please describe the parameters of the department's definition of "statewide basis".	See Amendment #3 to the RFP.
373	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states - Entities eligible to submit a bid under this RFP in accordance with SSL § 365-f shall include: An entity capable of performing statewide fiscal intermediary services with demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce with experience serving individuals with disabilities and as of April 1st, 2024, is providing services as a fiscal intermediary on a statewide basis in at least one other state. Please confirm that an applicant would satisfy the Minimum Qualifications regarding performance of "fiscal intermediary services" if it performs services on a statewide basis in another state that satisfy the NYS descriptions of "Fiscal Intermediary Services", even if the applicant is not called a "fiscal Intermediary" in the other state.	See Amendment #3 to the RFP.
374	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	The use of the term "shall" in the eligibility criteria suggests a mandatory requirement. However, given the ambiguity around the phrase "providing services as a fiscal intermediary on a statewide basis in at least one other state," can the Department define what constitutes "statewide basis" and specify the level of service penetration required to meet this criterion?	See Amendment #3 to the RFP.
375	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Can we get clarification on what "statewide basis" means with regards to fiscal intermediary services as there are varying levels of involvement "statewide" in other states.	See Amendment #3 to the RFP.
376	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Can the Department provide a precise definition or criteria for what constitutes statewide service provision to ensure consistent and fair evaluation of bids?	See Amendment #3 to the RFP.

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377	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Given these specific requirements and definitions that apply uniquely to New York State, can the Department clarify how an SFI that only provides similar but not identical services in a different state can meet the qualifications?	See Amendment #3 to the RFP.
378	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Do the minimum qualifications in this section require that an entity, to be eligible to submit a bid under the RFP, be a current provider of fiscal intermediary services in New York State? In other words, can an entity that currently performs no fiscal intermediary services in New York State be eligible to submit a bid under the RFP? Similar but different question from the first question in this item 9: Do the minimum qualifications in this section require that an entity, to be eligible to submit a bid, currently perform fiscal intermediary services in New York State on a statewide basis?	An entity does not need to be a fiscal intermediary in New York State to be eligible.
379	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Section 3.1 (a) states, "…on a statewide basis…". How is 'statewide basis' defined?	See Amendment #3 to the RFP.
380	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Section 3.1 (a) states, "…on a statewide basis in at least one other state."; Attachment B checkbox one states, "…on a statewide basis with at least one other state.". Was the different wording unintentional? If it was not, which term is correct. If so, can you please explain the difference?	See Amendment #3 to the RFP.
381	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What specific evidence or documentation will be required from an out-of-state SFI to demonstrate their capability to perform the full spectrum of New York State fiscal intermediary services, as defined by New York's statutes and regulations?	See RFP Section 6.2.D. and Attachment B.
382	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What specific documentation is required to demonstrate that our organization meets the minimum qualifications as a fiscal intermediary as outlined in Section 3.1 of the RFP?	See RFP Section 6.2.D. and Attachment B.
383	Eligibility	Section 4.0: Scope of Work (Page 5 of RFP)	What does the term "entity" mean?	See Amendment #3 to the RFP.
384	Eligibility	Section 4.0: Scope of Work, Third Bullet (Page 5 of RFP)	Does the FI's existing statewide service have to be a CDPAP program?	See Amendment #3 to the RFP.
385	Eligibility	Section 6.2.D: Documentation of Bidder's Eligibility Responsive to Section 3.0 of RFP (Page 21 of RFP)	In order to achieve a successful transition to a single FI in NY, it is critical that bidders not only have experience serving members statewide, but also bring experience with a direct contract with a State. To qualify as the single FI do bidders need to have a contract directly with another state?	See Amendment #3 to the RFP.
386	Eligibility	Section 6.2.D: Documentation of Bidder's Eligibility Responsive to Section 3.0 of RFP (Page 21 of RFP)	Please note the earlier question regarding the difference between this language and the statutory language, specifically the distinction, if any, between providing fiscal intermediary service "in" vs. "with" at least one other state.	See Amendment #3 to the RFP.
387	Emergency Preparedness	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP) and Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	What specific components should be included in the disaster preparedness and emergency plans?	The proposal should demonstrate how the Statewide Fiscal Intermediary will continue operations and continuity of required FI services, as outlined in RFP Section 4.0, to CDPAP consumers in the event of any emergency or disaster. The plan should clearly demonstrate that it ensures continued provision of FI services as required in the RFP and resulting contract.
388	Emergency Preparedness	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	In times of crisis, such as natural disasters or pandemics, the adaptability and responsiveness of multiple entities are crucial. How does the Department plan to ensure the same level of adaptability and responsiveness with a single Statewide FI?	See answer to Question #387

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389	Emergency Preparedness	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	RFP Section 4.5 Paragraph H and RFP Section F.3 Paragraph 8: "h) Establish, maintain, and periodically review disaster preparedness and emergency plans and procedures related to the provision of required FI services;" and "Describe the establishment, maintenance, and periodic review of the bidder disaster preparedness and emergency plans and procedures related to the provision of required FI services." The RFP omits education to the consumers on Disaster/Emergency plan as to how the FI will fulfill its responsibilities as previous DOH documents required this. The RFP does not include education to the consumer, or DR if applicable, steps they can do to prepare for a disaster or emergency. Emergency/Disaster education is something many current Fis provide as it can save lives such as the Blizzard that occurred in Buffalo, NY where many people died.	See answer to Question #387
390	Evaluation	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Will the Department otherwise measure a bidder's creditworthiness in reviewing a bidder's proposal?	The specific components of the Department's evaluation will not shared with the bidding community.
391	Evaluation	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Will the Department otherwise consider a bidder's financial strength in reviewing a bidder's proposal?	The specific components of the Department's evaluation will not shared with the bidding community.
392	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	Will there be an opportunity for bidders to receive feedback on their proposals to understand how scoring decisions were made?	No.
393	Evaluation	Section 8.3: Technical Evaluation (Page 26 of RFP) and Section 8.4: Cost Evaluation (Page 26 of the RFP)	How will the technical and cost proposals be weighted in the evaluation process, and what specific criteria will be used to score them?	A Bidder's Technical Proposal will be weighted 65% of the overall score and a Bidder's Cost Proposal will be weighted 35% of the overall score. Bidders should reference Section 6.2.F of the RFP for information that should be provided in their Technical Proposal.
394	Evaluation	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Will a bidder's proposal be more highly scored if the bidder provides a larger line of credit?	No
395	Evaluation	Section 5.10: Encouraging Use of New York Businesses in Contract Performance (Page 17 of RFP)	Regarding this section, will New York-based businesses be given preferential consideration in this procurement?	No.
396	Evaluation	Section 5.10: Encouraging Use of New York Businesses in Contract Performance (Page 17 of RFP)	Will the Department consider whether a Bidder is an existing New York state business when evaluating the bids?	No.
397	Evaluation	Section 8.0: Method of Award (Pages 25-27 of RFP)	Would the Department consider adding an oral presentation with a solution demonstration to the evaluation process?	No.
398	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	Will the DOH make public its scoring and ranking of each Single FI candidate?	No.
399	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	Define best value.	See paragraph 1 within Section 8.1 of the RFP.
400	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	Section 8.1 states that the "Technical Proposal and compliance with other RFP requirements (other than the Cost Proposal) will be weighted 65% of a proposal's total score" and that "the information contained in the Cost Proposal will be weighted 35% of a proposal's total score." The RFP provides no further guidance regarding how the Cost Proposal will be scored. Is a proposal's total Cost Proposal-related score based purely on Proposed PMPM? What is the relationship between Proposed PMPM and Cost Proposal score? Objective and transparent scoring criteria are necessary to limit DOH staff members' discretion and ensure that bids are evaluated fairly and impartially by DOH.	See Section 8.4 of the RFP, which provides the formula related to how Cost Proposals will be scored.
401	Evaluation	Attachment A: Bidder Document Checklist (Page 28 of RFP)	Are points awarded for completion of the Administrative Proposal, or is it simply pass/fail?	The Administrative Proposal will not be scored as part of the Technical or Cost Evaluation process.
402	Evaluation	General	During the procurement process the NY DOH has discretion to include "other criteria" in order to make their choice on who they will contract with. Can DOH please provide in depth clarification on what the exact and full criteria is?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
403	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	How will the Department of Health address potential disparities in the interpretation of "Best Value" among different members of the Evaluation Committee?	This information will not be shared with the bidding community

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404	Evaluation	Section 5.8: DOH's Reserved Rights (Page 16 of RFP)	What criteria will be used to evaluate information obtained from site visits and interviews?	This information will not be shared with the bidding community.
405	Evaluation	Section 6.1.3: Vendor Responsibility Questionnaire (Page 18 of RFP)	What specific elements will be assessed in the Vendor Responsibility Questionnaire, as outlined in Section 6.1.3 of the RFP?	This information will not be shared with the bidding community.
406	Evaluation	Section 6.1.10: MWBE Forms (Page 20 of RFP)	The RFO requires the submission of Attachment 5 (M/WBE Utilization Plan.). However, section 5.5. states "for purposes of this RFP, DOH establishes an overall goal of 0% for M/WBE participation.." What scoring advantages will be awarded to a bidder (if any) that is a NY M/WBE?	This information will not be shared with the bidding community.
407	Evaluation	Section 8.0: Method of Award (Pages 25-27 of RFP)	RFP Sections 8.3 Technical Evaluation and 8.4 Cost Evaluation describe the method of evaluation. Is the Administrative Proposal evaluated? If so, please describe the evaluation criteria.	This information will not be shared with the bidding community.
408	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	What agencies will be represented on the RFO Evaluation committee?	This information will not be shared with the bidding community.
409	Evaluation	Section 8.2: Submission Review (Page 26 of RFP)	Who will be involved in the evaluation of SFI applications?	This information will not be shared with the bidding community.
410	Evaluation	Section 8.2: Submission Review (Page 26 of RFP)	How will the selection group evaluate and make its final decision?	This information will not be shared with the bidding community.
411	Evaluation	Section 8.3: Technical Evaluation (Page 26 of RFP)	The RFP states that the evaluation process will be conducted by a technical evaluation committee. Will this committee be able to reach out to the other state(s) the bidder operates to assess how accurate their responses are to what they do on that other state?	This information will not be shared with the bidding community.
412	Evaluation	Section 8.3: Technical Evaluation (Page 26 of RFP)	The RFP states that the evaluation process will be conducted by a technical evaluation committee. Will this committee conduct site visits to bidder locations in other states to conduct audits and ensure the veracity of claims made in the bidders' submissions?	This information will not be shared with the bidding community.
413	Evaluation	Section 8.3: Technical Evaluation (Page 26 of RFP)	Will the DOH's Evaluation Team include part-time state employees or outside consultants?	This information will not be shared with the bidding community.
414	Evaluation	Section 8.3: Technical Evaluation (Page 26 of RFP)	How will the 65 points available for the Technical Evaluation be awarded and weighed by section in the Technical Response? For example, how many maximum points are available for the EVV section?	This information will not be shared with the bidding community.
415	Evaluation	Section 8.3: Technical Evaluation (Page 26 of RFP)	Will the Department review bidder experience as part of the Technical Evaluation?	This information will not be shared with the bidding community.
416	Evaluation	Section 8.3: Technical Evaluation (Page 26 of RFP)	Does the Department have a model proposal it will examine bidder proposals against?	This information will not be shared with the bidding community.
417	Evaluation	Section 8.3: Technical Evaluation (Page 26 of RFP)	Will the Technical Evaluation Committee be trained in how proposals should be reviewed and evaluated?	This information will not be shared with the bidding community.
418	Evaluation	Section 8.4: Cost Evaluation (Page 26 of the RFP)	The RFP states that there is a separate cost evaluation committee. Can that committee reach out to other state(s) the bidder is operating to learn how efficiently they operate compared to what they describe?	This information will not be shared with the bidding community.
419	Evaluation	Section 8.4: Cost Evaluation (Page 26 of the RFP)	Can DOH identify the members and experience of the Cost Evaluation Committee and/or indicate whether the Committee will include DOH Program Staff?	This information will not be shared with the bidding community.
420	Evaluation	Section 8.6: Best and Final Offers (Page 26 of RFP)	What specific criteria will be used in the Best and Final Offer process to ensure it adheres to the "Best Value" concept as specified in Section 8.1?	This information will not be shared with the bidding community.
421	Evaluation	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	What are the key elements that you consider most critical in the technical proposal?	This information will not be shared with the bidding community. Bidders should follow the instructions included throughout Section 6 and any applicable attachments when responding to this RFP.
422	Evaluation	Section 4.2: Best Practices (Page 6 of RFP)	Several of the best practices listed in Section 4.2 seem crucial to the success of this system. How will meeting "best practices" be included in the technical evaluation scoring?	This information will not be shared with the bidding community. Bidders should follow the instructions included throughout Section 6 and any applicable attachments when responding to this RFP.

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423	Evaluation	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet b) (Page 8 of RFP)	How will the qualifications of administrative staff be evaluated and measured by the Department of Health?	This information will not be shared with the bidding community. Bidders should follow the instructions included throughout Section 6 and any applicable attachments when responding to this RFP.
424	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	Section 8.1 states that the "Technical Proposal and compliance with other RFP requirements (other than the Cost Proposal) will be weighted 65% of a proposal's total score" and that "the information contained in the Cost Proposal will be weighted 35% of a proposal's total score." Section 6.2 further elaborates that the Technical Proposal will be evaluated based on the bidder's ability to "meet the fiscal intermediary services as included in Sections 4.0 through 4.7." How will DOH score and weigh the dozens of discrete services, practices, and requirements set out in Sections 4.0 through 4.7 in determining a total Technical Proposal score? This information is needed in order for bidders to evaluate their eligibility or fitness for the contract and prepare their bids appropriately, and to limit DOH staff members' discretion and ensure that bids are evaluated fairly and impartially by DOH.	This information will not be shared with the bidding community. Bidders should follow the instructions included throughout Section 6 and any applicable attachments when responding to this RFP.
425	Evaluation	Section 8.4: Cost Evaluation (Page 26 of the RFP)	For the Cost Evaluation, will ineligible bidders be excluded from the cost calculation?	Yes, if the Bidder is ineligible, their proposal will not proceed to the Technical or Cost Evaluation Teams.
426	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	There is no mention of a potential request for Oral Presentation by select Bidders. Does DOH reserve the right to request Oral Presentations?	Oral presentations are not anticipated; however, under Section 5.8.5 DOH reserves the right to seek clarification from bidders.
427	Evaluation	General	Will extra consideration be given to entities that currently operate in New York State?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
428	Evaluation	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder must be "capable of performing statewide fiscal intermediary services..." What metrics will be used to determine the bidder's capacity to perform such statewide fiscal intermediary services?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
429	Evaluation	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder must be "capable of performing statewide fiscal intermediary services..." Does this mean that a bidder will have to show previous experience performing these services in another state?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
430	Evaluation	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder must be "capable of performing statewide fiscal intermediary services..." Will it be deemed acceptable for a bidder use the experience of subcontractors to meet this standard?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
431	Evaluation	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder must, as of April 1, 2024, serve as an FI on a "statewide basis in at least one other state". To what extent will the Department weigh the comparability of that other state to NYS? That is, will the Department consider population size, cultural and language diversity, etc. of that other State and how that experience might compare to NYS?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
432	Evaluation	Section 3.1: Minimum Qualifications (Page 4 of RFP)	The RFP states that any qualified bidder must, as of April 1, 2024, serve as an FI on a "statewide basis in at least one other state". To what extent will the Department weigh the comparability of how that other State structures the functions of fiscal intermediaries to how the functions of fiscal intermediaries are defined under NYS law?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
433	Evaluation	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Can the Department outline the process and criteria for evaluating whether an out-of-state SFI's prior experience in other states aligns with New York State's comprehensive fiscal intermediary responsibilities, including wage and benefit processing, compliance with PA workers' compensation, and monitoring consumer's ability to self-direct?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
434	Evaluation	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What criteria will be used to evaluate whether an entity is capable of performing statewide fiscal intermediary services?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
435	Evaluation	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	How will the Department evaluate demonstrated experience in other states to apply to capability within the New York state CDPAP model?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.

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436	Evaluation	Section 4.0: Scope of Work, Paragraph 1 (Page 5 of RFP)	Given the significant functional differences in fiscal intermediary services within New York State as defined by the specified section of Part HH when compared to other state models, how will the Department evaluate experience represented within bidders' proposals to correspond to the unique programmatic needs of New York State's model of consumer directed service delivery?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
437	Evaluation	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	The RFP states that the awarded Statewide FI will have and maintain an effective organizational structure with qualified administrative staff to deliver all services of the Statewide FI and ensure all FI personnel have the appropriate training and knowledge to fulfill their duties to the FI. How does the state define 'effective'?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
438	Evaluation	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	The RFP states that the awarded Statewide FI will have and maintain an effective organizational structure with qualified administrative staff to deliver all services of the Statewide FI and ensure all FI personnel have the appropriate training and knowledge to fulfill their duties to the FI. How will the state determine if an organizational system is effective?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
439	Evaluation	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	The RFP states that the awarded Statewide FI will have and maintain an effective organizational structure with qualified administrative staff to deliver all services of the Statewide FI and ensure all FI personnel have the appropriate training and knowledge to fulfill their duties to the FI. How will the state define 'qualified'?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
440	Evaluation	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	The RFP states that the awarded Statewide FI will have and maintain an effective organizational structure with qualified administrative staff to deliver all services of the Statewide FI and ensure all FI personnel have the appropriate training and knowledge to fulfill their duties to the FI. Will the state include the appropriate cultural and language capacities in defining 'qualified'?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
441	Evaluation	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	The RFP states that the awarded Statewide FI will have and maintain an effective organizational structure with qualified administrative staff to deliver all services of the Statewide FI and ensure all FI personnel have the appropriate training and knowledge to fulfill their duties to the FI. How will the state determine who is 'qualified'?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
442	Evaluation	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	If the awardee is unable to provide proof of the line of credit within 10 days, will the DOH move to award the bidder with the second-highest score?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
443	Evaluation	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Will DOH provide any scoring advantage of any kind to proposals based on the number of proposed subcontracting arrangements? For example, if Bidder A identifies in its technical proposal a comprehensive list of Subcontractors (from which it has secured letters of intent) that demonstrates how it will provide culturally and linguistically competent services in all areas of the State while Bidder B defers to cooperating with DOH to develop an adequate network of subcontractors, will the first bidder be preferenced in any way under the scoring methodology?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
444	Evaluation	Section 5.7: Subcontracting (Pages 15-16 of RFP)	How does the Department define and evaluate the role of subcontractors in fulfilling the FI services? Are there specific qualifications subcontractors must meet?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
445	Evaluation	Section 6.1: Administrative Proposal (Page 18 of RFP)	If evaluations of the Administrative, Technical, and Cost components of Proposals are conducted separately, how will the Department effectively determine if the costs specified within a given proposal are sufficient to support the programmatic functions, best practices, and quality assurance components outlined within a separate section of the same proposal?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
446	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	When considering "best value", are the services, quality enhancements, and mandatory/voluntary benefits factored in on the decision?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.
447	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	What measures are in place to ensure that the Department of Health's "sole discretion" in determining the best proposal does not lead to subjective or biased decision-making?	The specific components of the Department's evaluation will not shared with the bidding community. Bidders should submit their Technical Proposal in accordance with Section 6.2 of the RFP.

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448	EVV	Section 5.7: Subcontracting (Pages 15-16 of RFP)	This section of the RFP may require the FI to contract with "an EVV vendor". Should bidders provide alternative proposals, i.e., with and without the cost of an EVV vendor when submitting their bids?	All bidders are required to have an EVV system that meets all New York State and federal EVV requirements. If a bidder does not have their own EVV system, they would need to contract with an outside EVV vendor.
449	EVV	Attachment B: Bidder's Demonstration of Eligibility to Submit an Offer (Pages 29-30 of RFP)	Section 5.7 of this RFP specifies that the Statewide FI "shall… contract with an EVV vendor, if necessary, to collect and submit data to the NYS Aggregator in accordance with the 21st Century Cures Act and NYS EVV standards and policies" (emphasis added). However, the Joint Employment Attestation included within ATTACHMENT B mandates that the Statewide FI "will contract with an EVV vendor." Is contracting with an EVV vendor a best practice or a requirement under this RFP?	Having an EVV system that is compliant with all federal and state laws, rules and regulations is a requirement of bidders. Whether this system is created in-house or subcontracted by the Statewide Fiscal Intermediary is a decision of the bidder.
450	EVV	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet i) (Pages 7-8 of RFP)	What are the details of the EVV requirements given the Aggregator model NY has been using?	Information related to New York State's EVV program can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/evv/
451	EVV	Section 5.7: Subcontracting (Pages 15-16 of RFP)	This section of the RFP may require the FI to contract with "an EVV vendor". Does the State have a preferred vendor?	No. New York State has a provider choice model for EVV, therefore the provider is able to choose their own EVV vendor that is able to comply with all New York State and federal EVV requirements.
452	EVV	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	The RFP states that "fiscal intermediary services **shall not** include fulfillment of the responsibilities of the consumer..." which, in (d) includes "Timely approving and attesting to the accuracy of PA time records and transmitting such information to the FI according to the FI's procedures." Does this mean that the consumer, must have access to the backend of the electronic visit verification record system to approve and deny service hours, and how does this occur if the consumer does not have the necessary electronic equipment to perform such a task?	No. The Statewide Fiscal Intermediary would be expected to procure an EVV vendor for personal assistants to use that complies with all EVV requirements.
453	EVV	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	In 4.4(i) the Statewide FI is identified as being responsible for complying with "Electronic Visit Verification requirements the Department has implemented or will implement to comply with the federal 21st Century Cures Act." However, in 4.1, the consumer is responsible for, and the fiscal intermediary **shall not** engage in "Timely approving and attesting to the accuracy of PA time records and transmitting such information to the FI according to the FIs procedures." Please clarify how these two provisions successfully interact with each other.	See answer to Question #452
454	EVV	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet i) (Pages 7-8 of RFP)	Will the statewide FI be required to provide alternative EVV compliance systems?	See answer to Question #449
455	EVV	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Will subcontractors be expected to contract with EVV vendors to collect PA time records?	See answer to Question #449
456	EVV	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Will any subcontractor have to move to the EVV system used by the statewide FI?	See answer to Question #449
457	EVV	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet h) (Page 9 of RFP)	How will the Department assess and determine EVV compliance? What specific reporting standards and compliance thresholds will be utilized?	See answer to Question #449
458	EVV	Section 4.8: Information Technology Requirements (Page 10 of RFP)	Will the Information Technology used to comply with EVV be fully ADA compliant and accessible?	See answer to Question #449
459	EVV	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Please clarify the expectations of contracting with EVV vendors.	See answer to Question #449
460	EVV	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Under the last bullet, who is the NYS aggregator?	The NYS Aggregator is the electronic system and mechanism through which EVV data is submitted to New York State

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461	EVV	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	Is the statewide FI responsible for verifying and auditing EVV data?	Yes.
462	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	Who is responsible for ensuring that the reporting requirements to OMIG are met?	Bidders are responsible for ensuring reporting requirements are met.
463	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet c) (Page 9 of RFP)	Will the awarded Statewide FI be required to retain and preserve financial and other records of FIs ceasing operations?	No, the statewide fiscal intermediary does not have to retain financial and other records of previous fiscal intermediaries unless those records are related to ongoing consumer activity in the program.
464	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet a) (Page 9 of RFP)	Since the cost report submission is based on a calendar year and services will be provided by the single statewide FI beginning April 1, 2025, please confirm who is responsible for submitting cost report data for the four months from Jan. 2025 - April 2025? Would that be the responsibility of the existing FIs within their individual 2025 Cost Reports? And then the single statewide FI would be responsible beginning April 1, 2025 until Dec. 31, 2025? Is it possible to either apply an alterative rate calculation for the first year's cost report or allow services to be effective with the beginning of the calendar year, either 2025 or 2026?	Submission timelines will be handled with the awardee upon contract execution
465	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	What are the details of the required fiscal procedures and internal controls mentioned in Section 4.6?	Refer to RFP Section 4.6 for the required fiscal monitoring and oversight requirements.
466	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	Section 4.6 (c): Is the single FI solely liable for the retention and preservation of financial and other records that facilitate fiscal monitoring and audits? Will DOH allow the single FI to transfer this risk to subcontractors? Will DOH allow indemnification provisions in subcontracts related to this risk? Will DOH allow indemnification provisions in subcontracts related to other financial and audit risks?	Bidders should consult with their legal counsel.
467	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	Section 4.6(d): How is "fiscal oversight" defined? This refers to fiscal oversight over whom? The PA? The consumer? The subcontractor? How is "fiscal integrity" defined? This refers to which party's fiscal integrity? What are the consequences if an undefined party does not meet undefined fiscal integrity standards?	Refer to RFP Section 4.6 for the required fiscal monitoring and oversight requirements.
468	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	Section 4.6(e): Is the single FI solely liable for OMIG risk? What is the allocation of risk and responsibility between the single FI and subcontractors for making OMIG referrals? Will DOH allow the single FI to transfer this risk to subcontractors? Will DOH allow indemnification provisions in subcontracts related to this risk?	Bidders should consult with their legal counsel.
469	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	Section 4.6(g): Is the single FI solely liable for OMIG risk and other audit risk as described in this section? What is the allocation of risk and responsibility between the single FI and subcontractors in this section? Will DOH allow the single FI to transfer this risk to subcontractors? Will DOH allow indemnification provisions in subcontracts related to this risk?	Bidders should consult with their legal counsel.

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470	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullets E and G (Page 9 of RFP)	RFP Section 4.6 Paragraphs E & G: "Establish and implement corporate compliance policies and procedures in accordance with the Federal Deficit Reduction Act and the False Claims Act to prevent, detect and report fraud, waste and abuse by board members, employees and consumers, and develop strategies to prevent and detect such fraud. The awarded Statewide FI along with its subcontractors, will refer to the Office of the Medicaid Inspector General (OMIG) any allegations of fraud, waste and abuse identified. For more information, see the CMS website on the Medicaid Integrity Program, found here: https://www.cms.gov/Medicare-MedicaidCoordination/Fraud-Prevention/MedicaidIntegrityProgram/index.html" and "Along with its subcontractors, the awarded Statewide FI will be subject to audit, investigation, and review by OMIG for a period consistent with the requirements outlined in 18 NYCRR Part 517. The awarded Statewide FI and its subcontractors will work cooperatively with the Department of Health, Office of the State Comptroller (OSC), OMIG, the New York State Office of the Attorney General, the Department of Health and Human Services (DHHS), the DHHS Office of Inspector General (OIG), and their designated representatives by furnishing any records and information upon request." Will the Statewide be audited on their investigation process and documentation of any fraud, abuse, and neglect of the consumer? What will be the frequency of this oversight? If there is a need for CDPAP Service to be suspended, such as if the consumer's home is environmentally dangerous to the PA, what agency or agencies have the authority to suspend service?	Bidders should consult with their legal counsel regarding federal and state agency oversight authority.
471	FOIL	Section 5.9: Freedom of Information Law ("FOIL") (Page 16 of RFP)	How should sensitive information be marked and justified as exempt from disclosure under FOIL?	FOIL redactions should be requested within the Bidder's Administrative Proposal. See Section 6.1.2 of the RFP.
472	FOIL	Section 5.9: Freedom of Information Law ("FOIL") (Page 16 of RFP)	What specific information will DOH require when evaluating and handling FOIL requests regarding proprietary information?	See response to Question #471
473	FOIL	Section 5.9: Freedom of Information Law ("FOIL") (Page 16 of RFP)	What procedures should subcontractors follow to mark information as confidential?	See response to Question #471
474	FOIL	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	Is the requirements of subsection b and c subject to the freedom of information law?	See response to Question #471
475	Health Assessment	Section 4.1: Required Fiscal Intermediary Services, Bullet d) (Page 5 of RFP)	NYCRR 766.11(c) and (d) states the requirements for Personal Assistant (PA) assessments. Who pays for the TB risk assessment? How much does the TB risk assessment cost?	It is the Personal Assistant's responsibility to have their health assessment conducted.
476	Health Assessment	Section 4.1: Required Fiscal Intermediary Services, Bullet d) (Page 5 of RFP)	NYCRR 766.11(c) and (d) states the requirements for PA assessments. Who pays for an annual or frequent health status assessment? How much do the health status assessments costs?	It is the Personal Assistant's responsibility to have their health assessment conducted.
477	Health Assessment	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	What "medical documentation" is required by Section 4.1(b)?	Medical documentation pertains to the health assessment as required by 10 NYCRR § 766.11(c) and (d).
478	Health Assessment	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Is the reference to "medical documentation" as "required by 4.1(b)" intended to change the current standards for PA health assessments? Our understanding is that PA health assessments do not require the involvement of a physician or physician assistant. See also RFP Section 4.4.	Medical documentation pertains to the health assessment as required by 10 NYCRR § 766.11(c) and (d).
479	Health Assessment	Section 4.1: Required Fiscal Intermediary Services, Bullet d) and e) (Page 5 of RFP)	In sections 4.1 d and 4.1 e, the RFP refers to assessing health status of the PA, as well as obtaining documentation of such. What documentation is required for the FI to obtain? Additionally, what items are being assessed by the FI?	Medical documentation pertains to the health assessment as required by 10 NYCRR § 766.11(c) and (d).

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480	Health Assessment	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Section 4.1(b) does not refer to medical documentation. Can you clarify the reference to medical documentation in Section 4.1(e)?	Medical documentation pertains to the health assessment as required by 10 NYCRR § 766.11(c) and (d). The reference in 4.1(e) should be to 4.1(d) and not 4.1(b). See Amendment #3.
481	Health Assessment	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	The RFP states that the fiscal intermediary is responsible for "Ensuring the health status of each PA is assessed prior to service delivery 10 NYCRR 766.11(c) and (d) or any successor regulation." Currently, fiscal intermediaries must assess prior to service and annually. Does this reflect a change in policy related to health assessments? Please clarify.	No, this is still an annual requirement.
482	Health Assessment	Section 4.1: Required Fiscal Intermediary Services, Bullet c) (Page 5 of RFP)	Can the FI obtain a statement of medical clearance from the doctor stating okay to perform essential functions rather than an actual physical examination report?	No. The health assessment is required to follow 10 NYCRR § 766.11(c) and (d).
483	Health Assessment	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	The RFP states that the fiscal intermediary is responsible for "Ensuring the health status of each PA is assessed prior to service delivery 10 NYCRR 766.11(c) and (d) or any successor regulation." 10 NYCRR 766.11(d)(6) requires "documentation of vaccination against influenza, or wearing of a surgical or procedure mask during the influenza season, for personnel who have not received the influenza vaccine for the current influenza season, pursuant to section 2.59 of this Title." Pursuant to Frequently Asked Questions (FAQ) Regarding Title 10, Section 2.59 "Regulation for Prevention of Influenza Transmission by Healthcare and Residential Facility and Agency Personnel" (January 2, 2015), CDPAP is exempt from this requirement. Will the statewide fiscal intermediary need to ensure compliance with 10 NYCRR 766.11(d)(6) or does the exemption remain in place?	The masking requirement exemption for CDPAP remains in place.
484	Health Assessment	Section 4.1: Required Fiscal Intermediary Services, Bullet d) (Page 5 of RFP)	Who is responsible for the cost of health assessments, the fiscal intermediary or the PA?	It is the Personal Assistant's responsibility to have their health assessment conducted.
485	Health Assessment	Section 4.1: Required Fiscal Intermediary Services, Bullet d) (Page 5 of RFP)	If the fiscal intermediary is responsible for the cost of the health assessment, will the Department, managed care plans, managed long-term care plans, Local Departments of Social Services, and other appropriate long-term service programs offering consumer directed personal assistance services reimburse the fiscal intermediary for these costs?	It is the Personal Assistant's responsibility to have their health assessment conducted.
486	Health Assessment	Section 4.1: Required Fiscal Intermediary Services, Bullet d) (Page 5 of RFP)	NYCRR 766.11 (c) and (d) states that documentation for vaccination against influenza must be maintained (or the PA must wear a mask during season). Who pays for influenza vaccination when needed? How much do flu vaccines cost?	It is the Personal Assistant's responsibility to have their health assessment conducted.
487	Health Assessment	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Will the selected FI be required to pay for PA health assessments?	It is the Personal Assistant's responsibility to have their health assessment conducted.
488	Health Assessment	Section 4.1: Required Fiscal Intermediary Services, Bullet d) (Page 5 of RFP)	Relating to the annual health assessment of the PA, will be scheduling and payment be covered by the new statewide FI?	It is the Personal Assistant's responsibility to have their health assessment conducted.
489	In home visits	Section 4.2: Best Practices, Bullet b) (Page 6 of RFP)	Will the statewide fiscal intermediary be required to conduct in-person visits with the consumer at their home?	The RFP states that bidders may used creative approaches to assist in the delivery of high quality FI services that best meet the needs of consumers. The best practices identified in Section 4.2 are not required but will be evaluated.
490	In home visits	Section 4.2: Best Practices, Bullet b) (Page 6 of RFP)	Is conducting visits to the consumer's home a best practice, when many Consumers are protective of their autonomy and privacy?	See answer to Question #489
491	In home visits	Section 4.2: Best Practices, Bullet b) (Page 6 of RFP)	How many in-person home visits per year will the fiscal intermediary be required to conduct?	See answer to Question #489
492	In home visits	Section 4.2: Best Practices, Bullet b) (Page 6 of RFP)	RFP Section 4.2 Paragraph B: "b) Conducting visit(s) to the consumer's home;" Please clarify when the Statewide FI or Subcontractor should conduct home visits to consumers? What frequency and in what situations/purpose?	See answer to Question #489

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493	In home visits	Section 4.2: Best Practices (Page 6 of RFP)	The RFP states bidders may use creative approaches to assist in the delivery of high quality FI services. Among the best practices is conducting visits to the consumer's home. Does the consumer have the right to consent to such visits?	See answer to Question #489
494	In home visits	Section 4.2: Best Practices (Page 6 of RFP)	Will the consumer have the right to refuse a home visit as a "high-quality FI services"?	Yes.
495	In home visits	Section 4.2: Best Practices, Bullet a) (Page 6 of RFP)	Can an FI or its subcontractors utilize video conferencing to conduct a visit to the consumer's home and/or conduct face-to-face orientations?	Yes.
496	In home visits	Section 4.2: Best Practices, Bullet b) (Page 6 of RFP)	Is Consumer consent required before the selected bidder may visit a Consumer's home?	Yes.
497	Insurance	Section 5.6.1: Data Breach and Privacy/Cyber Liability including Technology Errors and Omissions (Page 14 of RFP)	Can the Single FI and all subcontractors be under one policy for a total of $5,000,000 in coverage, or must each entity have its own coverage?	Each entity must have its own coverage. Per section 5.6.1, with regard to Data Breach and Privacy/Cyber Liability Insurance, "[t]he Contractor and any subcontractor retained by the Contractor shall carry and maintain applicable coverage during and for a period of two (2) years after termination of this contract, Data Breach and Privacy/Cyber Liability Insurance, including coverage for failure to protect confidential information and failure of the security of the Contractor's computer systems or the Department's Authorized Users' systems due to the actions of the Contractor which results in the unauthorized access to the Department's data." (emphasis added).
498	Insurance	Section 5.6.1: Data Breach and Privacy/Cyber Liability including Technology Errors and Omissions (Page 14 of RFP)	Are there any requirements specific to General Liability insurance?	General Liability insurance requirements can be found in Attachment 8 as referenced in Section 5.6 of the RFP.
499	IT	Section 4.8: Information Technology Requirements (Page 10 of RFP)	What specific IT systems or software are required to meet the Information Technology Requirements outlined in Section 4.8?	Bidders will need to have IT systems that allow them to adequately, securely and appropriately conduct all responsibilities required of the Statewide Fiscal Intermediary. Bidders should describe this in their proposal.
500	IT	Section 4.8: Information Technology Requirements (Page 10 of RFP)	Will the accessibility requirements of other sections of this RFP apply to Information Technology considerations?	See answer to Question #499
501	IT	Section 4.9: Privacy, Security and Confidentiality Requirements (Pages 10-11 of RFP)	Who will be the parties to the security and privacy agreements (i.e., Data Use Agreements and Business Associate Agreements) described in this section? Will there be third-party beneficiaries to these agreements?	A prepopulated Data Use Agreement (DUA) will be provided to the organization after the contract is awarded and is fully executed. The DUA contains a Business Associate's Agreement (BAA) which is between the Contractor and the Department. DOH will have absolute authority to determine if, and when, any other party may be allowed to access information The purpose of the Data Use Agreement (DUA) is to assure DOH that a Requesting Organization (Requestor) will maintain the security and privacy of Medicaid Confidential Data (MCD) that DOH releases to the Requestor. An additional purpose of the DUA is to establish a legally binding agreement between the Requestor and DOH by defining the terms and conditions of the MCD release, should DOH accept the Requestor's Agreement.
502	IT	Section 4.9: Privacy, Security and Confidentiality Requirements (Pages 10-11 of RFP)	What are the detailed expectations for data privacy and security, particularly concerning compliance with HIPAA and NYS policies?	The awarded Statewide FI will comply fully with all current and future NYS privacy, confidentiality, and security policies and standards, as well as with all applicable State and federal requirements, in performance of this contract. This shall include all privacy and security policies and procedures of the Department (https://its.ny.gov/eiso/policies/security) and applicable state and federal law, rules, regulations, and administrative guidance with respect to the performance of this contract. See Appendix H included in Attachment 8.

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503	IT	Section 5.6.1: Data Breach and Privacy/Cyber Liability including Technology Errors and Omissions (Page 14 of RFP)	Can you provide more detail on the insurance requirements, particularly the Data Breach and Privacy/Cyber Liability Insurance, as outlined in Section 5.6 of the RFP?	See the NYS Department of Health Contract as part of Attachment 8.
504	IT	Section 5.6.1: Data Breach and Privacy/Cyber Liability including Technology Errors and Omissions (Page 14 of RFP)	Does the Privacy/Cyber insurance need to be from an institution based in New York State? Can the insurance issuer also be the line of credit issuer?	See the NYS Department of Health Contract as part of Attachment 8.
505	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Will the Statewide FI, with more than 100 employees, be required to complete annual federal EEO reporting, including data for both administrative employees and personal assistant workers? How will the Department ensure compliance with these reporting requirements?	The Bidder should consult with the federal EEOC regarding the impact of joint employer status on the annual filing requirement. Any compliance obligations under federal law that may arise out of the joint employer attestation should be evaluated by a Bidder with its labor and employment counsel.
506	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Under joint employer status, will the Statewide FI be responsible for meeting large employer requirements under the ACA, ensuring health insurance coverage for personal assistants, and facing potential penalties for non-compliance? What specific ACA-related responsibilities will the Statewide FI assume?	The Bidder should consult with the IRS regarding the impact of joint employer status on ACA-related responsibilities. Additionally, any compliance obligations under federal law that may arise out of the joint employer attestation should be evaluated by a Bidder with its labor and employment counsel.
507	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	The RFP states that the **AWARDED STATEWIDE FI** shall accept a role as a joint employer. Does this mean that the Awarded Statewide FI is a large employer for purposes of the Affordable Care Act and therefore must provide health insurance benefits?	See answer to Question #506
508	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Under joint employment, would it be more appropriate for the Statewide FI to register as a professional employer organization, and should individual policies be considered to cover both the Statewide FI entity and consumers explicitly? How will the Department address these requirements?	No. A professional employer organization is a co-employer and not a joint employer. The concept of joint employment is that the Statewide FI and the consumer will each have certain employment related responsibilities to the personal assistant. The joint employer attestation asks Fiscal Intermediaries (FI) to acknowledge their status as a joint employer for the purpose of the services, delineated at SSL 365-f (4-a), to ensure that FI services and obligations are provided in compliance with applicable law, while also maintaining consistent state-wide operation of, and standards applicable to, the Consumer Directed Personal Assistance Program (CDPAP). In keeping with NY caselaw regarding the FI's role as joint employer, and to achieve a consistent statewide standard, the joint employment attestation requires the FIs to acknowledge that their relationship to PAs is an employer-employee relationship as determined by and to the extent that FIs are responsible for employment related practices in statute and regulation. Each bidder should consult with its legal counsel regarding the role of the Medicaid CDPAP FI as a joint employer under current NY caselaw.
509	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet f) (Pages 6-7 of RFP)	Does the "coordinating of annual leave" include scheduling when/if a PA takes time off?	Consumers are responsible for scheduling their personal assistants including when they take time off.
510	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet k) (Pages 6-7 of RFP)	Will there be a procedure code for FMLA and paid leave benefits?	No.

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511	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet k) (Pages 6-7 of RFP)	How will the FI pay for FMLA and paid leave?	The Statewide FI will be responsible for the payment of all required and promised wage supplements (fringe benefits) as well as all required paid leave. The Statewide FI will also be obligated to ensure that employees are provided with all required unpaid leave and associated protections.
512	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	The RFP states that the Fiscal Intermediary must acknowledge its role, with the consumer, as a joint employer of the personal assistant. Is the FI acknowledging its role as a joint employer for the purposes of the Fair Labor Standards Act (FLSA), under common law, or both?	Yes, the FI would be acknowledging its role as a joint employer for purposes of the federal Fair Labor Standards Act, the New York State Labor Law, and relevant common law.
513	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	The RFP states that the Fiscal Intermediary must acknowledge its role, with the consumer, as a joint employer of the personal assistant. As a joint employer who, pursuant to 4.1(a) is establishing the wage of personal assistants, the liability for timely payment of the personal assistant would fall to the fiscal intermediary; however, also pursuant to 4.1 in the second (f), the fiscal intermediary is prohibited from "Timely distributing PAs' employment checks, if physical check distribution by the Consumer to the PA is the means of payment the Consumer and PA agree upon." How can the bidder accept liability for actions it is not legally allowed to control?	Section 4.1 explains that FIs are not responsible for "[t]imely distributing PAs' employment checks, if physical check distribution by the Consumer to the PA is the means of payment the Consumer and PA agree upon". FIs are expected to issue physical checks in a timely manner, if that is the selected method for payment.
514	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet a) (Pages 6-7 of RFP)	Can the FI mandate that all PAs, with the exception of minors, receive their net payroll by either direct deposit or by fee-free debit card?	No.
515	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	The term "joint employer" is used throughout the RFP. In Section 4.3, it states, "The awarded Statewide FI will accept and acknowledge its role as Fiscal Intermediary is that of a joint employer, with the CDPAP consumer, of the personal assistant (PA)." Please confirm our understanding of this term through an example. For example, if my 90-year-old mother lives independently and participates in CDPAP, would she be the "joint employer" CDPAP consumer, along with the statewide FI of the PA providing services in her home? If yes, does that mean the statewide FI must obtain a copy of attachment B from everyone consumer serving as a "joint employer" to the PA as in the example provided here?	Only the bidder must submit the Attachment B form.
516	Joint Employer	Section 4.2: Best Practices, Bullet d) (Page 6 of RFP)	Will there be additional information provided by the Department as to the legal obligations as joint employers for both the consumer and the FI?	Refer to RFP Section 4.3. See answer to Question #505
517	Joint Employer	Section 4.2: Best Practices, Bullet d) (Page 6 of RFP)	Are there any other specific activities for which the Department believes that the consumer and the fiscal intermediary are joint employers?	Refer to RFP Section 4.3.
518	Joint Employer	Section 4.1: Required Fiscal Intermediary Services, Paragraph 1 (Page 5 of RFP)	Is it mandatory for the Statewide FI to be the employer of record for all personal assistants in the state?	Yes.
519	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	How does the joint employment role impact subcontractors, and what specific responsibilities will subcontractors have in this capacity?	Only the contracted statewide fiscal intermediary will be considered a joint employer. Subcontractors are responsible for the duties as outlined in their subcontract with the contracted statewide fiscal intermediary but ultimately the contracted statewide fiscal intermediary is responsible for the contract deliverables and the work of their subcontractors.
520	Joint Employer	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Would it be permissible for a subcontractor to be specified as the joint employer, in addition to both the consumer and the Statewide FI?	See answer to Question #519

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521	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Do Centers for Independent Living take on any liability as joint employers if they are performing FI services?	See answer to Question #519
522	Joint Employer	Section 4.2: Best Practices (Page 6 of RFP)	Will subcontractors be considered joint employers with consumers, or is joint employment held by the Statewide FI?	See answer to Question #519
523	Joint Employer	Section 4.2: Best Practices, Bullet d) (Page 6 of RFP)	Please explain the limits to a fiscal intermediary providing support in recruiting, interviewing, supervision and termination when Social Services Law section 365-f(4-a)(a)(iii) prohibits fiscal intermediaries from recruiting, hiring, training, supervising, scheduling, and terminating personal assistants.	See answer to Question #508.
524	Joint Employer	Section 4.2: Best Practices, Bullet d) (Page 6 of RFP)	In describing each of the following as a responsibility of the consumer as a "joint employer," is it the Department's view that the fiscal intermediary is a joint employer for each of the following activities: recruiting, interviewing, dealing with difficult employees, effectively supervising, and terminating employment? Please respond separately for each activity.	See answer to Question #508.
525	Joint Employer	Section 4.2: Best Practices, Bullet d) (Page 6 of RFP)	Providing support for consumers to assist them in their role as a joint employer in areas including, but not limited to recruiting, interviewing, dealing with difficult employees, effective supervision, and termination of employment; However, Section 4.1 states the following: Fiscal Intermediaries are not responsible for, and fiscal intermediary services shall not include fulfillment of the responsibilities of the consumer. Responsibilities of the consumer (or designated representative) include: a) Managing their own plan of care including recruiting and hiring PAs; b) Training, scheduling and supervising PAs including arranging and scheduling substitute coverage when a PA is temporarily unavailable for any reason; c) Assuring PAs competently and safely perform the required services; d) Timely approving and attesting to the accuracy of PA time records and transmitting such information to the FI according to the FIs procedures; e) Timely notifying the FI of changes in employment status of any PA; f) Timely distributing PAs' employment checks, if physical check distribution by the Consumer to the PA is the means of payment the Consumer and PA agree upon; and g) Terminating Pas. Please provide clarification with examples of how an FI is to support and assist for consumer responsibilities in which Section 4:1 states the FI is not responsible for such as recruiting, interviewing, and termination of employment.	See answer to Question #508.
526	Joint Employer	Section 4.2: Best Practices (Page 6 of RFP)	Who is considered the employer of record?	The Statewide Fiscal Intermediary will be the employer of record.
527	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Can DOH state whether the Joint Employer requirements differ from the RFP contract in place today where the FI is an Agency with Choice provider, and if the requirements differ, describe what may be considered a net new requirement under the term "Joint Employer?"	There are currently no contracts in place with fiscal intermediaries in New York State.
528	Joint Employer	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	The RFP states that it is the statewide FI's responsibility to process wages and benefits for each personal assistant (PA). Given the "joint employment" arrangement with the Consumer of the PA as described in RFP Section 4.3 Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, please confirm that it is the statewide FI's responsibility to comply with NYS law section 3614-F, Home care minimum wage increase and NYS law section 3614-C, Home care worker wage parity.	Yes, the Statewide Fiscal Intermediary is responsible for complying with all wage and labor laws including minimum wage and wage parity under PHL 3614-F and PHL 3614-C, respectively.

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529	Joint Employer	Section 4.2: Best Practices, Bullet a) (Page 6 of RFP)	In a joint employment environment, could a best practice include providing underutilized staff from one consumer for another consumer who is struggling to hire staff?	Yes, with the consumer's consent to have the Statewide Fiscal Intermediary assist with finding potential personal assistants. It would still be the responsibility of the consumer to interview and hire those individuals, as well as train, schedule and terminate the personal assistant. The Statewide Fiscal Intermediary cannot insist a consumer hire any particular personal assistant.
530	Joint Employer	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Processing wages and benefits for each personal assistant (PA), including establishing the amount of each PA's wages; As a third party fiduciary we are not the responsible party for wage setting, if awarded the contract, will the contracted entity be a joint employer, and wage set for the CDPAP Program Individuals?	Yes. See RFP 4.1 (a) and 4.3.
531	Joint Employer	Section 4.1: Required Fiscal Intermediary Services, Bullet f) (Page 5 of RFP)	RFP Section 4.1 F: Timely distributing PAs' employment checks, if physical check distribution by the Consumer to the PA is the means of payment the Consumer and PA agree upon; is a consumer responsibility with the section stating the FI must not. Then the RFP page 29 states under Joint Employment: a) Ensuring full and timely payment of wages established by the Offeror per applicable federal and state labor laws, including wage parity and overtime laws, preferably by direct deposit, and providing all statements and maintaining all records required by the New York State Labor Law; Please clarify if the consumer in responsible to ensure the PA receives payment or if the FI is responsible. If both the consumer and FI; what is the best practice to share this responsibility.	See answer to Question #513.
532	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Can you elaborate on the joint employment responsibilities outlined in Section 4.3, particularly regarding wage setting and benefit coordination.	See answer to Question #511.
533	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Must the selected statewide fiscal intermediary be a joint employer for all purposes or only for the purposes specifically listed in Section 4.3 of the RFP?	See answer to Question #508.
534	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Will the Statewide FI be held jointly liable for instances of discrimination, harassment, or retaliation if it knew or should have known about such conduct and failed to take appropriate steps to stop it? What protocols will be established to address and prevent these issues?	See answer to Question #508.
535	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	What retirement plan structure requirements will be imposed on the Statewide FI for personal assistants under joint employment? Will a multiple employer plan be necessary, and how will the Department ensure these requirements are met?	See answer to Question #508.
536	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	What liability will the Statewide FI assume for risks in locations where personal assistants provide services, particularly regarding automobile accidents where the personal assistant is the driver or otherwise responsible? How will these liabilities be managed under joint employment?	See answer to Question #508.
537	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Under 4.3 f, there is a requirement to coordinate health insurance. Is health insurance mandated? if so, what are the particulars of the mandate?	Section 4.3(f) of the RFP states that the Awarded Statewide FI will be responsible for: "Coordinating PA benefits, including annual leave, health insurance and employee benefits as applicable"

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538	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet f) (Pages 6-7 of RFP)	Do PA's have their health insurance provided by the Single FI?	See answer to Question #537
539	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet f) (Pages 6-7 of RFP)	Will the Statewide FI be required to provide health insurance benefits to personal assistants?	See answer to Question #537
540	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet f) (Pages 6-7 of RFP)	RFP Section 4.3 Paragraph F: "f) Coordinating PA benefits, including annual leave, health insurance and employee benefits as applicable" Please clarify what the benefits will be for Personal Assistants? Currently, some Fiscal Intermediaries offer PA benefits above State/Federal requirements. What is the reference to annual leave – is this sick time?	Annual leave refers to paid time off.
541	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	For bullet f), when establishing and paying annual leave, how are those paid from the authorizations? Or is there a separate authorization code for annual leave?	Annual leave will not be paid through an authorization; it should be considered as a component of the PMPM calculation.
542	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	How will the Department ensure that the Statewide FI effectively administers FMLA for personal assistants who work for multiple consumers or designated representatives, coordinating to return employees to the same or equivalent positions? Will the Department provide guidelines or resources to manage this administrative complexity?	See RFP Section 4.4.
543	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	The RFP states that the **AWARDED STATEWIDE FI** is responsible for "Coordinating PA benefits, annual leave, health insurance, and employee benefits, as applicable." Is the Awarded Statewide FI or the consumer responsible for informing the PA of the availability, scope, changes to, and cost, if applicable, of any such benefit offered?	The statewide FI will be responsible to communicate with PAs regarding any function it performs.
544	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	The RFP states that the **AWARDED STATEWIDE** FI is responsible for "(h) Maintaining and making available to the Consumer information detailing the wage rates and benefits of PAs." Does the Awarded Statewide FI have to communicate with the consumer what benefits are available to the PA, what benefits the PA has opted to receive, or both?	See answer to Question #537
545	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	The RFP states that the Fiscal Intermediary must acknowledge its role, with the consumer, as a joint employer of the personal assistant. Joint employment brings with it requirements to comply with a number of different requirements that have historically not applied to CDPA, such as OSHA safe workplace laws and liability for sexual harassment or discrimination when such actions are performed by the consumer, another PA in the consumer's home, or an individual that is in the home with the consumer. Please clarify as to whether this is the intent.	See answer to Question #508.
546	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Will the Statewide FI be responsible for ensuring personal assistants receive appropriate safety training and notices, and could it be cited for safety violations at consumer locations? What authority does the Department have to override federal OSHA standards, and how will joint employer responsibilities be delineated?	See answer to Question #508.

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547	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Section 4.3 As a joint employer, will the Statewide FI have direct responsibility under federal law to ensure all required safety training for personal assistants is completed timely? What are the potential legal liabilities if the Statewide FI fails to report that a consumer is not fulfilling their responsibilities and is potentially not self-directing?	See answer to Question #508.
548	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Can the Department clarify how the single statewide FI will be able to maintain local presence and responsiveness in each region while centralizing operations, especially in rural and underserved areas?	The Department has not defined timely delivery of services as it relates to maintaining a local presence in each of the outlined rate regions. The bidder should demonstrate in its Technical Proposal how they plan to maintain a local presence that allows for the timely delivery of services. How the bidder, through its own means or those of a subcontractor, meets this requirement is at the bidder's discretion and should be described in the Technical Proposal.
549	Local Presence	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet g) (Pages 7-8 of RFP)	How many physical locations are required per identified region?	See answer to Question #548
550	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	Is a statewide FI with limited subcontractors going to maintain local presence in rural and underserved areas of New York State?	See answer to Question #548
551	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	What is considered maintaining a local presence?	See answer to Question #548
552	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet f) (Page 8 of RFP)	How many accessible locations in each region will the statewide FI provide?	See answer to Question #548
553	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	May the subcontractor support the Statewide FI by providing support staff at one or more of the regional offices?	See answer to Question #548
554	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	How many local presence offices in each region will the statewide FI provide?	See answer to Question #548
555	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Will local offices of subcontractors count towards determining whether the statewide FI has a sufficient regional presence?	See answer to Question #548
556	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Does “local presence” include a physical office? Will a bidder receive extra points for a physical office?	See answer to Question #548
557	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	What are the specific requirements regarding maintaining a local presence in each region of the state? Is the local presence one per region, or more than one per region? Does this depend upon the region of the state?	See answer to Question #548
558	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Can this local presence requirement be met through subcontractors?	See answer to Question #548
559	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Does “local presence” include a call center? Will a bidder receive extra points for a call center?	See answer to Question #548

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560	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Can the Department define what constitutes a "local presence" for Statewide FI bidders, such as the requirement for a physical office or acceptable alternatives? Does the Statewide FI bidder need to establish a physical office in New York State prior to April 1, 2024, which is the minimum qualification date the eligible Statewide FI must have provided fiscal intermediary services, to qualify as an eligible Statewide FI? How will the Department verify and evaluate this local presence to ensure compliance and readiness for service delivery across the state?	See answer to Question #548
561	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Can subcontractors of the Statewide FI fulfill the local presence requirement in each region of the state?	See answer to Question #548
562	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	How is the term "local presence" defined by the Department? What specific expectations does this requirement entail?	See answer to Question #548
563	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	This section specifies that the Statewide FI must "maintain a local presence in each regions of the state"; does this require the Statewide FI to have a physical office within each identified State region? Can this stipulation be met through subcontracting relationships?	See answer to Question #548
564	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	The RFP states, "Maintain a local presence in each region of the state (see Attachment D), that ensures the Statewide FI can effectively and timely deliver the services required in Section 4.0." Does the single statewide FI require a local presence or office in every County listed in Attachment D or only 3 offices in total for each of the 3 regions listed in Attachment D?	See answer to Question #548
565	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Section 4.5(g) of the RFP requires the SFI to maintain a local presence in each MLTC rating region. Does a local presence require the SFI to maintain a physical, brick and mortar location? Does the location have to be made available to consumers or to PAs? Or can the SFI maintain a local presence through other means or a combination of means?	See answer to Question #548
566	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	The statewide fiscal intermediary is required to maintain a local presence in each region of the state (see Attachment D). What is the definition of "a local presence in each region"?	See answer to Question #548
567	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Will a statewide fiscal intermediary be required to maintain an office in each region set forth in Attachment D?	See answer to Question #548
568	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	RFP Section 4.5 Paragraph G: g) Maintain a local presence in each region of the state (see Attachment D), that ensures the Statewide FI can effectively and timely deliver the services required in Section 4.0; and RFP Section 4.3 Paragraph 2: Describe how the FI plans to maintain a local presence that ensures the awarded Statewide FI can effectively and timely deliver the services required by Section 4.0. Please clarify what is meant by a local presence in each region. Does this mean an actual office or remote staff? Is a subcontractor considered a local presence for the Statewide FI?	See answer to Question #548
569	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Will a statewide fiscal intermediary be required to maintain a presence in each county listed in each region as set forth in Attachment D?	See answer to Question #548
570	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Will a statewide fiscal intermediary be required to have an office in each county listed in each region as set forth in Attachment D so that CDPAP consumers, attendants, and self-directing others have a familiar contact?	See answer to Question #548
571	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Does this requirement mean that the FI Bidder must also have an Albany, on-site presence to interact with state officials more expeditiously?	See answer to Question #548
572	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Would meaningful member and PA interaction in a region qualify as "local presence?"	See answer to Question #548

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573	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Can the FI presence in each region be accomplished through the sub-contract requirements in the RFP?	See answer to Question #548
574	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	The RFP states that the awarded Statewide FI must "Maintain a local presence in each region of the state (see Attachment D)..." Pursuant to the MLTC regions established, the Statewide FI could fulfill this obligation by placing offices in Port Jefferson (Suffolk), Nyack (Rockland), Kinderhook (Columbia), and Troy (Rensselaer). Please clarify as to whether or not such an arrangement would fulfill this obligation.	See answer to Question #548
575	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	Section 4.5 of the RFP also states that the awarded contractor must maintain a local presence in each region of the state. Does this mean at least one office in each of the 4 rate regions? Or does this mean at least one office in each county throughout New York state? Or something else?	See answer to Question #548
576	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	4.5 Fiscal Intermediary Organizational Requirements, states: "The awarded Statewide FI will:….g) Maintain a local presence in each region of the state (see Attachment D), that ensures the Statewide FI can effectively and timely deliver the services required in Section 4.0;" Given that the counties listed within the same region are generally not contiguous, what is specifically meant by "maintain a local presence in each region of the state?"	See answer to Question #548
577	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Can subcontractors of the Statewide FI fulfill the local presence requirement in each region of the state?	See answer to Question #548
578	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	The awarded FI will: "maintain a local presence in each region of the state" Does each region mean "Capital District Region, Central New York Region, Metropolitan Area Region and Western Region" or something else?	See answer to Question #548
579	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet g) (Page 8 of RFP)	Can the Statewide FI illustrate that it "maintain(s) a local presence in each region of the state" by demonstrating that it currently provides FI services to Medicaid beneficiaries in each region of the state? (i.e., Capital District Region, Central New York Region, Metropolitan Area Region and Western Region)	See answer to Question #548
580	Local Presence	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	4.5 Fiscal Intermediary Organizational Requirements, states: "The awarded Statewide FI will:….g) Maintain a local presence in each region of the state (see Attachment D), that ensures the Statewide FI can effectively and timely deliver the services required in Section 4.0;" Given that the regions with contiguous counties are large geographically or present other challenges when travelling throughout the region, what is specifically meant by "maintain a local presence in each region of the state?"	See answer to Question #548
581	Local Presence	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet g) (Pages 7-8 of RFP)	Does this require the Statewide FI to have a brick and mortar presence in each region?	Not necessarily. See answer to Question #548
582	MCO Contracting	Section 5.4: Payment (Page 12 of RFP)	Regarding Section 5.4.2, "Direct Care Service Costs", does the state expect that the Statewide FI will negotiate individual contracts with 60+ Managed Care Plans? Or will the State direct or benchmark statewide or regional direct care payment rate(s)?	This question is not relevant to the development of a proposal under this RFP.
583	MCO Contracting	Section 5.4: Payment (Page 12 of RFP)	Will MCO's be required to contract with the Statewide FI at the direct care rate and administrative rate determined by the Statewide FI?	This question is not relevant to the development of a proposal under this RFP.
584	MCO contracting	General	Does NYS intend to set one set of claim rates for all MCOs?	This question is not relevant to the development of a proposal under this RFP.
585	MCO contracting	General	Will the FI be required to negotiate rates with each MCO, or will the MCOs follow the same set of guidelines for rates?	This question is not relevant to the development of a proposal under this RFP.
586	MCO Contracting	Section 5.4: Payment (Page 12 of RFP)	Is the Department's intent for the FI to negotiate rates with each MCO, or would a single rate be set by the State for each MCO?	This question is not relevant to the development of a proposal under this RFP.
587	MCO Contracting	Section 5.4: Payment (Page 12 of RFP)	Are MCO's required to honor the payrate as established by NY State?	This question is not relevant to the development of a proposal under this RFP.

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588	MCO Contracting	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet e) (Pages 7-8 of RFP)	Will the Department require the MCO or LDSS, as applicable, to provide additional reimbursement to the selected FI to provide PA compensation in counties in which the Wage Parity law applies?	The Statewide FI must comply with all existing laws and regulations, including wage parity where applicable.
589	MCO contracting	General	What are the current reimbursement rates by MCO?	Current reimbursement rates may vary by MCO.
590	MCO contracting	Section 2.1: Background Information (Page 3 of RFP)	May a PACE Plan contract for Fiscal Intermediary services with an entity, other than the winning statewide FI?	No.
591	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Under the new regulations for PACE, a PACE applicant must be approved under section 365-f of the New York State Social Services Law (SSL). Is a PACE program required to submit a response to provide Fiscal Intermediary services as part of this RFP?	No.
592	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Will the insurance plans waive timely filing requirements because the consumer is responsible for timely approving and attesting to the accuracy of PA time records and transmitting such information to the FI?	The insurance plans will follow all state and federal requirements.
593	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services, Bullet h) (Page 5 of RFP)	Does the state mandate claims processing timelines the MCOs must adhere to?	The insurance plans will follow all state and federal requirements.
594	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services, Bullet h) (Page 5 of RFP)	What happens if the selected FI cannot come to agreement with a particular MCO?	MCOs can only contract with the Selected FI for Fiscal Intermediary Services
595	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Will bidders be expected to describe in detail or provide examples of how they have entered into administrative agreements with MCOs?	See Section 6.2 of the RFP for information that should be provided in a bidder's Technical Proposal.
596	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services, Bullet h) (Page 5 of RFP)	Does the reference to MCOs also include managed care plans, managed long-term care plans, Local Departments of Social Services, and other appropriate long-term service programs offering consumer directed personal assistance services?	"MCO" refers to managed care plans. Only the selected FI will be permitted to bill for any CDPAP service or administration costs.
597	MCO Contracting	Section 4.0: Scope of Work (Page 5 of RFP)	What happens if the selected bidder is unable to contract with one or more managed care plans, managed long-term care plans, Local Departments of Social Services, and other appropriate long-term service programs offering consumer directed personal assistance services to provide all fiscal intermediary services to consumers as required by Social Services Law section 365-f(4-a(a)(ii-a)?	Managed care plans will be required to contract with the contracted statewide fiscal intermediary. Through the Department's contract, Local Departments of Social Services will be considered contracted with the Statewide Fiscal Intermediary and not enter into separate agreements with the contractor.
598	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Will service centers for independent living subcontracting with the Statewide FI be permitted to enter into administrative and/or reimbursement agreements with MCOs for the provision of FI services?	No. Only the statewide fiscal intermediary will enter into administrative agreements with managed care plans.
599	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Section 4.1 (h) states, "Entering into administrative and reimbursement agreements with MCOs for the provision of fiscal intermediary services;" Will the Statewide FI be entering into administrative and reimbursement agreements with LDSS' for the provision of fiscal intermediary services?	No. The contract with the State will serve as the agreement with all Local Departments of Social Services.
600	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services, Bullet h) (Page 5 of RFP)	Section 4.1 (H) mentions the Single FI must contract with MCOs. Will the DOH approve, or at minimum, annually review these contracts?	The Department does not review or approve contracts between managed care plans and their network providers.
601	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services, Bullet h) (Page 5 of RFP)	Will the MCOs be required to pay the selected FI the three-tiered PMPM as directed by the Department at amounts established by the Department?	The selected FI will be paid the PMPM amount awarded under this contract.
602	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	For section 4.1 (h): Will the MCOs be required by the State to pay the PMPM established as part of this RFP for administrative services?	The selected FI will be paid the PMPM amount awarded under this contract.
603	MCO Contracting	Attachment F: Cost Proposal (Page 34 of RFP)	Will the MCOs be required by the state to pay the established PMPM?	The selected FI will be paid the PMPM amount awarded under this contract.

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604	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services, Bullet h) (Page 5 of RFP)	Will the Single FI invoice the State or each payer?	The selected FI will work with both the State and the MCOs.
605	MCO Contracting	Section 5.4: Payment (Page 12 of RFP)	Will the State establish a service code for how the billing goes to the MLTCs?	This question is not clear and therefore cannot be answered.
606	MCO Contracting	Section 5.4: Payment (Page 12 of RFP)	If a service code is established, will this utilize the standing worker rate, or will it be negotiated with each MLTC for different rates?	This question is not clear and therefore cannot be answered.
607	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services, Bullet h) (Page 5 of RFP)	Will the selected FI be required to contract with all MCOs?	Yes
608	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services, Bullet h) (Page 5 of RFP)	Does the requirement to contract with MCO's include the Program of All-Inclusive Care for the Elderly (PACE)?	Yes. The statewide fiscal intermediary will enter into administrative agreements with all managed care plans that are obligated to provide consumer directed personal assistance services.
609	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services, Bullet h) (Page 5 of RFP)	Section 4.1 (H) mentions the Single FI must contract with MCOs. Does this include the Program of All-Inclusive Care for the Elderly (PACE)?	Yes. The statewide fiscal intermediary will enter into administrative agreements with all managed care plans that are obligated to provide consumer directed personal assistance services.
610	MWBE	Attachment 5: MWBE Forms	What if the applicant itself is a M/WBW entity, can this be indicated on the form?	A Bidder who is a certified NYS MWBE should still complete Form #4 and #5 as identified in Attachment 5. A Bidder should indicate they are a certified NYS MWBE within their submitted Attachment 7: Bidder's Certified Statements (see Section 2.A.)
611	MWBE	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	The RFP notes that the "DOH hereby establishes an overall goal of 0% for [minority and women-owned business] participation." Given this, will the DOH make efforts to ensure the inclusion of minority and women owned businesses in this industry? If so, what efforts will DOH make?	Although there is a 0% MWBE goal for the resulting contract, as stated in Section 5.5 of the RFP, bidders are strongly encouraged to engage with firms found in the MWBE directory.
612	MWBE	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	Even with a 0% goal for MWBE participation, are there still benefits or preferences for engaging MWBE firms, as outlined in Section 5.5 of the RFP?	Although there is a 0% MWBE goal for the resulting contract, as stated in Section 5.5 of the RFP, bidders are strongly encouraged to engage with firms found in the MWBE directory.
613	MWBE	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	What outreach efforts have been made to certified MWBE firms?	Although there is a 0% MWBE goal for the resulting contract, as stated in Section 5.5 of the RFP, bidders are strongly encouraged to engage with firms found in the MWBE directory.
614	MWBE	Section 6.1.10: MWBE Forms (Page 20 of RFP)	Can DOH provide clarification as to why the attachments in section 6.1.10 are required if there is a M/WBE goal of 0% participation?	Although there is a 0% MWBE goal for this RFP, engaging with firms found on the MWBE is strongly encouraged. See Section 5.5 of the RFP.
615	MWBE	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	While there is a 0% goal for MWBE participation, would the use of small, culturally appropriate Fiscal Intermediaries (FIs) as subcontractors be considered beneficial in the bid, as outlined in Section 5.5 of the RFP?	As stated in Section 5.5 of the RFP, engaging with firms found in the MWBE directory is strongly encouraged.
616	MWBE	Section 5.11: Participation Opportunities for NYS Certified Service-Disabled Veteran-Owned Businesses (Page 17 of RFP)	What specific actions should FIs take to promote and assist in the participation of SDVOBs in the contract?	In order to make good faith efforts to promote and assist in the participation of SDVOBs on the Contract, bidders should view the NYS SDVOB directory at: https://ogs.ny.gov/veterans/. Bidders are encouraged to contact the Office of General Services' Division of Service-Disabled Veteran's Business Development at 518-474-2015 or VeteransDevelopment@ogs.ny.gov to discuss methods of maximizing participation by SDVOBs on the Contract.

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617	MWBE	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	Can you provide more detail on the expectations and reporting requirements for M/WBE participation and Equal Employment Opportunity (EEO)?	Instructions related to the expectations and reporting requirements for MWBE participation and EEO can be found within Attachment 5 and on the New York State Contract System website: https://ny.newnycontracts.com/.
618	MWBE	Section 6.1.10: MWBE Forms (Page 20 of RFP)	Was the 0% a typographical error?	No.
619	MWBE	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	Although the DOH has set a 0% goal for minority and women-owned business participation in the Statewide FI bidding, will it set a goal higher than 0% for minority and women-owned business participation as subcontractors?	No. However, as stated in Section 5.5 of the RFP, bidders are strongly encouraged to engage with firms found in the MWBE directory.
620	MWBE	Section 6.1.10: MWBE Forms (Page 20 of RFP)	How can out-of-state businesses be certified as a NY M/WBE Vendor?	Out of state vendors are able to become certified as a NYS MWBE, provided they meet all other MWBE eligibility requirements and possess the "Authority to do Business in New York State" from the NYS Department of State (DOS). Additional information can be found at https://esd.ny.gov/doing-business-ny/mwbe.
621	MWBE	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	How was it determined that there is an overall goal of 0% for M/WBE under this RFP? The Single FI could use M/WBE vendors for items such as office supplies, etc., under their administrative costs.	This question is not relevant for a development of a proposal under this RFP. As stated in Section 5.5 of the RFP, bidders are strongly encouraged to engage with firms found in the MWBE directory.
622	MWBE	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	New York policy and executive orders require commitment to ensuring diversity in its procurements. Yet, Section 5.5 states, "DOH hereby establishes an overall goal of 0% for M/WBE participation." Further, DOH justifies this with saying that their determination is "based on the current availability of qualified MBEs and WBEs and outreach efforts to certified M/WBE firms." In our experience, M/WBE are crucial to the success of these programs and play important roles in all aspects of the program—even administrative tasks, such as mailing, etc. How can the Department justify saying that none of the hundreds of M/WBE firms available are unable to perform any duties under this contract, when there are so many that meet the requirements?	The RFP is not subject to State Finance Law Section 163.
623	MWBE	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	What is the basis for the Department's determination regarding qualified MBEs and WBEs?	The RFP is not subject to State Finance Law Section 163.
624	MWBE	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	Why does the Department believe there is not a single qualified MBE or WBE that can be the awarded contractor?	The RFP is not subject to State Finance Law Section 163.
625	MWBE	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	The RFP notwithstands MWBE standards. Are the forms related to that still required for the submission? Specifically, is the staffing plan required? If so, is information from subcontractors to be included?	Yes, see Section 5.5 of the RFP and Attachment 5 for additional information. Attachment 5, Form #4 should also be submitted for all planned subcontractors.

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626	Overtime	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet c) (Pages 6-7 of RFP)	Are PA hours aggregated across all consumers in the state to determine overtime and/or travel time?	Hours worked are evaluated at the individual worker level, regardless of the volume of consumers served.
627	Overtime	General	Can the single FI limit the number of hours a Personal Assistant (PA) can work beyond the authorized hours or over 40 hours per week? If not, will the FI be reimbursed for the costs of unauthorized hours and overtime?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
628	Overtime	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	The RFP states that "fiscal intermediary services shall not include fulfillment of the responsibilities of the consumer..." which, in (b) includes "Training, scheduling and supervising PAs including arranging and scheduling substitute coverage when a PA is temporarily unavailable for any reason." Does this prevent the Awarded Statewide FI from banning PAs from working overtime?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
629	Overtime	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	The RFP states that "fiscal intermediary services **shall not** include fulfillment of the responsibilities of the consumer..." which, in (b) includes "Training, scheduling and supervising PAs including arranging and scheduling substitute coverage when a PA is temporarily unavailable for any reason." When one PA works for multiple consumers, how does the Awarded Statewide FI limit or prevent the use of overtime without involving itself in the scheduling of the PAs between the two consumers?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
630	Overtime	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Does the processing of wages include a limitation of overtime? If there is a limitation, what is the limit?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
631	Overtime	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	How will emergency situations which require overtime be handled?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
632	Overtime	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	How will the Department ensure that the Statewide FI is compliant with federal and state labor laws regarding overtime, particularly when a personal assistant works more than 40 hours during a 7-day workweek across multiple consumers or designated representatives? What mechanisms will be in place to track and reconcile these hours accurately?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
633	Overtime	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Given the complexity of calculating minimum wage and overtime on a weekly basis, especially for travel time between shifts, how does the Department propose the Statewide FI manage this process to ensure compliance with New York frequency of pay rules? Will the Statewide FI be obligated to pay for travel time or breaks between shifts if the personal assistant does not have sufficient time to use for their own purposes?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
634	Overtime	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet c) (Pages 6-7 of RFP)	In the example provided, when services are rendered for multiple consumers by a single PA, what is the statewide fiscal intermediary's liability if services are rendered by a single PA in excess of the applicable overtime rules?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
635	Overtime	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet c) (Pages 6-7 of RFP)	In terms of "tabulating appropriate hours" does this include limitation on overtime?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.

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636	Overtime	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet a) (Pages 7-8 of RFP)	Section 4.4 (f) refers to overtime pay. Is the Statewide FI able to limit the amount of overtime a Consumer can schedule?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
637	Overtime	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet f) (Pages 7-8 of RFP)	Will the selected FI be able to limit the hours worked by any one PA?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
638	Overtime	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet f) (Pages 7-8 of RFP)	Will the Statewide FI be required to provide overtime pay?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
639	Overtime	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet f) (Pages 7-8 of RFP)	Will Statewide FI be required to provide overtime pay to PA's?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
640	Overtime	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet f) (Pages 7-8 of RFP)	As a joint employer, can the Fiscal Intermediary limit the amount of overtime worked by the PA?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
641	Overtime	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet f) (Pages 7-8 of RFP)	Under the current CDPAP reimbursement structure, the FI does not get reimbursed at the appropriate rate for overtime hours. Will the statewide FI have the right to work with consumers to require multiple PAs to manage overtime?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
642	Overtime	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	In 4.4(f), the Statewide FI is identified as being responsible for complying with "state and federal labor laws, including but not limited to laws pertaining to overtime pay." Is the Statewide FI permitted to prevent PAs from working overtime?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
643	Overtime	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	In 4.4(f), the Statewide FI is identified as being responsible for complying with "state and federal labor laws, including but not limited to laws pertaining to overtime pay." If a PA who serves multiple consumers works in excess of 40 hours in one week between the two consumers, which consumer's managed care organization shall be responsible for the payment of overtime pursuant to Public Health Law 3614-d?	Per NYS Law § 365-f and 18 NYCRR § 515.2, the Statewide Fiscal Intermediary cannot limit the number of hours a personal assistant can work.
644	PA Payment	Section 5.4: Payment (Page 12 of RFP)	Will the direct care service costs be determined by the Local Department of Social Services (LDSS)? Or will this be included as part of the submitted direct care cost proposal by the bidder?	This question is not relevant to the development of a proposal under this RFP.
645	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet c) (Page 5 of RFP)	Will the payment of various insurances be attributable to the PMPM administrative payment or to the direct care budget line?	This question is unclear and will not be answered.
646	PA Payment	Section 5.4: Payment (Page 12 of RFP)	Will Direct Care Service Costs include line items for: regional pay add-on, overtime pay, and off-standard hours pay?	This information is publicly available on the Department's website at https://www.health.ny.gov/health_care/medicaid/redesign/mrt61/2022-09-12_hcw_min_wage_guide.htm
647	PA Payment	Section 5.4: Payment (Page 12 of RFP)	What is the hourly Direct Care worker pay of which the Statewide FI will be reimbursed?	Current rate information is publicly available on the Department's website at https://www.health.ny.gov/facilities/long_term_care/reimbursement/cdpap/
648	PA Payment	Section 5.4: Payment (Page 12 of RFP)	How is the direct care labor cost calculated? Our current understanding is that this is generated from cost reports and varies by provider. Is this understanding accurate, and if so, will it be applied to the MCO PMPM process?	Current rate information is publicly available on the Department's website at https://www.health.ny.gov/facilities/long_term_care/reimbursement/cdpap/
649	PA Payment	Section 5.4: Payment (Page 12 of RFP)	What are the components of the direct care service cost rate?	Current rate information is publicly available on the Department's website at https://www.health.ny.gov/facilities/long_term_care/reimbursement/cdpap/

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650	PA Payment	Section 5.4: Payment (Page 12 of RFP)	How many service codes exist across the range of payers?	The Department does not have this information
651	PA Payment	Section 5.4: Payment (Page 12 of RFP)	The direct service cost—will it be reimbursed on an hourly unit?	Current rate information is publicly available on the Department's website at https://www.health.ny.gov/facilities/long_term_care/reimbursement/cdpap/
652	PA Payment	Section 5.4: Payment (Page 12 of RFP)	The direct service cost—will it include all PA payment-related expenses—PR taxes, WC, UEI, FLSA, Spread of Hours, WWP, etc. or will components be part of the administrative PMPM?	Current rate information is publicly available on the Department's website at https://www.health.ny.gov/facilities/long_term_care/reimbursement/cdpap/
653	PA Payment	Section 5.4: Payment (Page 12 of RFP)	If the direct service rate is set by the State, will a state-directed payment need to be approved by CMS?	No
654	PA Payment	Section 5.4: Payment (Page 12 of RFP)	Please provide the Fee For Service (FFS) Fee Schedule.	Current rate information is publicly available on the Department's website at https://www.health.ny.gov/facilities/long_term_care/reimbursement/cdpap/
655	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	What backup payments system will the Statewide FI be required to have in place in the event they are unable to process payments for the PAs? For example, if the $100,000,000 line of credit is maxed out, how will PAs be paid?	These terms are subject to the contractual agreement between the selected FI and the State.
656	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Will the Department of Labor accept the consumer is responsible for timely approving and attesting to the accuracy of PA time records and transmitting such information to the FI is a consumer responsibility as a defense for when a worker is paid months after the work is performed because the consumer did not approve?	No. Workers must be paid on time for work performed. Under New York Labor Law Section 191, manual workers (meaning individuals who spend more than 25% of work time engaged in "physical labor") must be paid weekly and no later than 7 calendar days after the end of the week in which the wages are earned. Large employers who meet the criteria set forth in Labor Law Section 191 may apply to the Commissioner of Labor for a variance of the requirement to pay employees weekly. If the FI is a non-profit organization, it may pay its manual workers semi-monthly without a variance.
657	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Will the managed care plans, managed long-term care plans, Local Departments of Social Services, and other appropriate long-term service programs offering consumer directed personal assistance services, as applicable, be required to compensate the selected FI for the provision of health care insurance to Personal Assistants?	The selected bidder will be responsible for complying with all applicable laws, rules, and regulations, both state and federal.
658	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Will the selected FI be required to provide health insurance under the Affordable Care Act as a large employer and, if so, will the Department compensate the selected FI for the provision of required health care insurance as required under the Affordable Care Act?	Any compliance obligations under federal law that may arise out of the joint employer attestation should be evaluated by a bidder with its labor and employment counsel.
659	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Will the selected FI be required to provide health insurance under the Affordable Care Act as a large employer and, if so, will the Department require the managed care plans, managed long-term care plans, Local Departments of Social Services, and other appropriate long-term service programs offering consumer directed personal assistance services, as applicable, to compensate the selected FI for the provision of required health care insurance as required under the Affordable Care Act?	Any compliance obligations under federal law that may arise out of the joint employer attestation should be evaluated by a bidder with its labor and employment counsel.
660	PA Payment	Attachment B: Bidder's Demonstration of Eligibility to Submit an Offer (Pages 29-30 of RFP)	Will the FI chosen be required to offer health insurance under the A.C.A.?	Any compliance obligations under federal law that may arise out of the joint employer attestation should be evaluated by a bidder with its labor and employment counsel.
661	PA Payment	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet a) (Pages 6-7 of RFP)	Are PA's "manual workers" under Labor Law 191 and must be pad on a weekly basis?	Manual workers are individuals who spend more than 25% of work time engaged in "physical labor" and must be paid on a weekly basis. Physical labor may include long hours standing as well as tasks such as lifting or turning clients. Large employers who meet the criteria set forth in Labor Law Section 191 may apply to the Commissioner of Labor for a variance of the requirement to pay employees weekly. If the FI is a non-profit organization, it may pay its manual workers semi-monthly without a variance.
662	PA Payment	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet a) (Pages 6-7 of RFP)	Are personal assistants classified as "manual workers" and therefore required to be paid weekly according to New York Labor Law Section 191?	See answer to Question #661

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663	PA Payment	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	In 4.4(g), the Statewide FI is identified as being responsible for complying with "Wage and labor agreements, including union contracts and collective bargaining agreements." Is the Awarded Statewide FI responsible for paying wages already established by existing FIs, or may they lower wages if the FI is paying above minimum wage?	The Department expects that bidders will comply with all federal and state labor and wage requirements.
664	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	If the Statewide FI fails to timely process PA payments what kind of contractual monetary penalties will be imposed?	It is expected that the SFI will draw upon the revolving credit facility required in section 5.6.2 to meet its payroll obligations under the contract. Each bidder is expected to consult with its own advisors regarding potential penalties or sanctions under the contract, and state and federal law, regarding potential ramifications of non-compliance under the contract.
665	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	What monetary penalties will be imposed for failure to have a backup payment system for failure to process payments?	See answer to Question #664
666	PA Payment	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	The contract involves over $8 billion in annual Medicaid payments. In the event of delays in payment for services, will the fiscal intermediary be expected to pay wages to Personal Assistants?	Yes, the SFI will be expected to meet its payroll obligations under the contract, with no delays in payment to personal assistants.
667	PA Payment	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Does the Department make a distinction between setting wages and establishing benefits for personal assistants and processing wages and benefits for personal assistants?	Yes. Setting wages and establishing benefits are a responsibility of the Statewide Fiscal Intermediary. Processing wages and benefits is the operational function of paying the personal assistant (e.g., through processing a direct deposit transaction).
668	PA Payment	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet a) (Pages 6-7 of RFP)	How is the preference for direct deposit to be accommodated if physical check distribution is requested by the Consumer?	Personal assistants may request physical check distribution.
669	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	What is the current payroll for Personal Assistants?	The Department does not have this information. Fiscal intermediaries are required to follow applicable wage and labor laws, rules and regulations including minimum wage and wage parity. Current minimum wage information is available at: https://dol.ny.gov/minimum-wage-home-care-aides-fare-grant and wage parity information is available at: https://www.health.ny.gov/health_care/medicaid/redesign/mrt_61.htm and https://dol.ny.gov/home-health-care-aides-and-wage-parity
670	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	What are the current wages for Personal Assistants?	See answer to Question #669
671	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Do the wages for Personal Assistants differ by region?	See answer to Question #669
672	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Will the Department make available information regarding the current wages of Personal Assistants to prospective statewide fiscal intermediaries?	See answer to Question #669
673	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Is it feasible that a single wage & benefit rate can be set for the entire state?	See answer to Question #669
674	PA Payment	Section 5.7: Subcontracting (Pages 15-16 of RFP)	If chosen through the procurement process, we would be considered subcontractors under the SFI, it seems we are not allowed to set the wages and benefits. Is this correct? If so, what are the proposed rates?	See answer to Question #669

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675	PA Payment	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	The RFP states that the "**AWARDED STATEWIDE FI,** on its behalf and on behalf of the consumers it serves, is responsible for: (a) Ensuring full and timely payment of wages established by the awarded Statewide FI, per applicable labor laws, preferably by direct deposit, and providing all statements and maintaining all records required by New York State Labor Law." However, pursuant to section 4.1, in the second (f), the fiscal intermediary "**SHALL NOT** include fulfillment of the responsibilities of the consumer..." which include, pursuant to (f) underneath, "Timely distributing PAs' employment checks, if physical check distribution by the Consumer to the PA is the means of payment the Consumer and PA agree upon." How can the Awarded Statewide FI be responsible for full and timely payment if it is not allowed to distribute checks to the PA in the event that a physical check is what the consumer and PA agree upon?	Each bidder should consult with its own legal counsel regarding its potential obligations under and compliance with federal and state wage, labor, and employment law.
676	PA Payment	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	The RFP states that the "**AWARDED STATEWIDE FI,** on its behalf and on behalf of the consumers it serves, is responsible for: (a) Ensuring full and timely payment of wages established by the awarded Statewide FI, per applicable labor laws, preferably by direct deposit, and providing all statements and maintaining all records required by New York State Labor Law." However, pursuant to section 4.1, in the second (f), the fiscal intermediary "**SHALL NOT** include fulfillment of the responsibilities of the consumer..." which include, pursuant to (f) underneath, "Timely distributing PAs' employment checks, if physical check distribution by the Consumer to the PA is the means of payment the Consumer and PA agree upon." In the event that the fiscal intermediary tabulates hours for multiple consumers by a single PA, and that PA elects for a physical paycheck, how shall the fiscal intermediary determine which of the consumers shall be responsible for delivering the physical paycheck to the PA?	Each bidder should consult with its own legal counsel regarding its potential obligations under and compliance with federal and state wage, labor, and employment law.
677	PA Payment	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	The RFP states that the "**AWARDED STATEWIDE FI,** on its behalf and on behalf of the consumers it serves, is responsible for: (a) Ensuring full and timely payment of wages established by the awarded Statewide FI, per applicable labor laws, preferably by direct deposit, and providing all statements and maintaining all records required by New York State Labor Law." However, pursuant to section 4.1, in the second (f), the fiscal intermediary "**SHALL NOT** include fulfillment of the responsibilities of the consumer..." which include, pursuant to (f) underneath, "Timely distributing PAs' employment checks, if physical check distribution by the Consumer to the PA is the means of payment the Consumer and PA agree upon." If one consumer is delivering a physical paycheck to a PA that is also working for a different consumer, does the consumer delivering the paycheck to the PA become a joint employer of the PA for the other consumer as well as themselves since they will control the provision of wages for the second consumer's PA?	Each bidder should consult with its own legal counsel regarding its potential obligations under and compliance with federal and state wage, labor, and employment law.
678	PA Payment	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet a) (Pages 6-7 of RFP)	What entity will be responsible for setting up the "direct deposit"? Will it be the responsibility of the PA and/or the FI?	The contracted statewide fiscal intermediary would work with the personal assistant to set up direct deposit of their wages.
679	PA Payment	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	For bullet a), how many PCAs receive payment via direct deposit today?	The Department does not have this information.
680	PA Payment	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	RFP states that the consumer or representative is responsible for distributing the PA's employment check if physical check distribution by the Consumer to the PA is the agreed upon means of payment. How many personal assistants are receiving paper checks?	The Department does not have this information.

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681	PA Payment	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet a) (Pages 6-7 of RFP)	Please provide the number of paper checks, direct deposit or other payment options, i.e., debit card payments made for the past 12 months by category.	The Department does not have this information.
682	PA Payment	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet a) (Pages 6-7 of RFP)	What is the standard payment schedule including frequency (i.e., weekly, bi-weekly, semi-monthly)?	The Department does not have this information.
683	PA Payment	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet a) (Pages 6-7 of RFP)	Does the reference to "wages established by the awarded Statewide FI" indicate that the Statewide FI has sole discretion to determine PA wages?	Yes, however the contracted statewide fiscal intermediary must abide by all wage laws, rules and regulations including, but not limited to, minimum wage and wage parity.
684	PA Payment	General	What service codes are allowable under this program for PCAs to perform?	CDPAP EVV applicable services codes are available on the DOH website at: https://www.health.ny.gov/health_care/medicaid/redesign/evv/repository/app_billing_codes.htm
685	PA Payment	General	Will there be travel time for PAs traveling between consumers on the same day?	This is defined in existing rules and regulations. Each bidder should consult with its own legal counsel regarding its obligations under federal and state wage, labor, and employment law.
686	PA Payment	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet a) (Pages 6-7 of RFP)	Please define "timely payment of wages." Will the FI be assessed a penalty if it fails to timely pay wages? Will past evidence of not timely paying wages result in a deduction of points in the scoring?	This is defined in existing rules and regulations. Each bidder should consult with its own legal counsel regarding its obligations under federal and state wage, labor, and employment law.
687	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	What benefits are required for each Personal Assistant?	All benefits required under federal and state law. Each bidder should consult with its own legal counsel regarding its obligations under federal and state wage, labor, and employment law.
688	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Will the Department compensate the selected FI for the provision of health care insurance to Personal Assistants?	The Department expects that bidders will comply with all federal and state labor and wage requirements.
689	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Does the Department currently have set pay rates for workers? If so, what are those pay rates by allowable service codes?	This information is publicly available on the Departments website.
690	PA Payment	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	When establishing and paying worker benefits, how are those paid from the authorizations? Or is there a separate authorization code for benefits?	This question is not relevant to the development of a proposal under this RFP.
691	PA Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	What benefits are currently being provided to Personal Assistants (PA) in CDPAP?	The Department does not have this information.
692	PA Payment	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Who is responsible for timely payments if time records are submitted or approved late by the consumer?	The Statewide FI will be responsible for timely payments.

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693	PA Payment	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet i) (Pages 6-7 of RFP)	Does the description of "Auditing Consumers' PA billing records" mean that the Department believes fiscal intermediaries are authorized to audit records maintained by Consumers?	This section refers to billing records submitted by the consumers to the Statewide Fiscal Intermediary for payment.
694	PA Payment	Attachment B: Bidder's Demonstration of Eligibility to Submit an Offer (Pages 29-30 of RFP)	If the chosen FI will offer health insurance, how will they bill the Department for health insurance costs? Or, is this cost to be included in the PMPM?	The Statewide FI must comply with all existing federal and state laws
695	PA Payment	Attachment 8: DOH Agreement, Appendix A, Clause H	As joint employers of the PAs, what level of health benefits would comply with this requirement? (e.g., silver QHP?)	Each bidder should consult with its own legal counsel regarding its obligations under federal and state wage, labor, and employment law.
696	Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet h) (Page 5 of RFP)	Does the state mandate the MCOs provide an Advance Payment of Pre-Funding of gross payrolls plus employer taxes?	Agreements between the Statewide Fiscal Intermediary and the MCOs will be negotiated by the parties.
697	Payment	General	How will the single statewide FI rates be determined in year 1 of providing services if they have no budgeted rate when they first start providing services and have not yet submitted a cost report or requested a budgeted rate?	The administrative cost PMPM will be paid to the Statewide Fiscal Intermediary as included in their Cost Proposal.
698	Payment	Section 5.4: Payment (Page 12 of RFP)	Please provide a breakdown of the costs that are included in "Administrative Costs" and the costs that are included in "Direct Care Service Costs".	This information is publicly available on the Department's website.
699	Payment	Section 6.3: Cost Proposal (Pages 24-25 of RFP)	For Fee-For-Service (FFS) consumers, how will the department establish a cost-based rate for a Statewide FI that does not currently contract in the state?	See answer to Question #698.
700	Payment	Attachment D: Region/County Mapping for MLTC Rate Setting Regions (Page 32 of RFP)	Will rates be based on costs and service statistics from services provided in a given NYS County or within the Region?	This question is not relevant to the development of a proposal under this RFP.
701	Payment	General	Is workers' compensation deducted from the budget?	This question is not clear and therefore cannot be answered.
702	Payment	General	Is the State prefunding payroll to the vendor?	No.
703	Payment	General	Does the state intend to provide an Advance Payment of Pre-Funding of gross payrolls plus employer taxes? If so, what is the amount?	See answer to Question #718
704	Payment	General	Is the FI allowed to deduct fees from worker paychecks?	Any deductions from wages must comply with New York Labor Law Section 193.
705	Payment	General	Is the Domestic Employee FICA Threshold refunding calculated on total wages across all consumers or on each consumer?	Each bidder should consult with its own legal counsel regarding its obligations under federal and state wage, labor, and employment law.
706	Payment	Section 5.4: Payment (Page 12 of RFP)	The RFP states that the "Payment for Administrative Costs will be based on the Contractor's Proposed Per Member Per Month (PMPM) price included in its submitted Attachment F: Cost Proposal." How does this interact with the legal PMPM payments established pursuant to 18 NYCRR 505.28?	The PMPM payments established pursuant to 18 NYCRR s. 505.28(k) predate and are superseded by the relevant provisions of the statutory amendment enacted by L.2024, c. 57, pt. HH, §§ 1 to 7.
707	Payment	General	Will the single State FI be required to comply with statutory payment requirements such as Prompt Pay? If yes, will this be a contractual requirement?	Section 4.4 of the RFP states: "In performing FI services described within the Scope of Work, the awarded Statewide FI must comply with all applicable State and federal laws, rules, regulations, and guidance…"
708	Payment	General	Currently, the FI vendors bill for full services, but only pay out a portion of their billing. The difference between the two is income or revenue to the FI. However, this contract calls for a PMPM as payment to the FI. Does the Department intend to stop the practice of allowing the FI to bill for the full services?	Administration will exclusively be paid through the PMPM established under this contract. Direct care will be paid through existing means with the expectation it flows to the worker
709	Payment	Attachment F: Cost Proposal (Page 34 of RFP)	Will there be a separate onboarding payment established in addition to the ongoing administrative fee?	No
710	Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet f) (Page 5 of RFP)	Does the Department intend to keep the authorization structure the same, or does it intend to move to a Budget Authority model?	No changes proposed

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711	Payment	Section 1.0: Calendar of Events (Page 3 of RFP)	The Contract will require substantial start-up activities by the selected FI. Will the selected FI be compensated for transition costs?	Transition costs will be paid through a separately bid PMPM as outlined in Amendment #3. The Cost Proposal form (Attachment F) has been revised to include this additional PMPM. All other on-going administrative costs for continued program implementation will be paid through the ongoing PMPM. There will be no other reimbursement outside these PMPM amounts other than direct care services costs.
712	Payment	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	Will the costs of the data collection, reports, and formats be chargeable to the Department?	See answer to Question #711
713	Payment	Section 4.8: Information Technology Requirements (Page 10 of RFP)	Will the Department provide funds to support the purchase of necessary Information Technology?	See answer to Question #711
714	Payment	Section 4.10: Transition Requirements, Paragraph 1 (Page 11 of RFP)	Will the department provide funding for start-up and transition costs for the new Statewide FI?	See answer to Question #711
715	Payment	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	Will there be start-up funding and transition costs for the new Statewide FI?	See answer to Question #711
716	Payment	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet e) (Pages 7-8 of RFP)	Will the Department provide additional reimbursement to the selected FI to provide PA compensation in counties in which the Wage Parity law applies?	Wage parity is factored into the direct care rates in those regions.
717	Payment	General	What is the average participant budget amount?	The Department does not have this information.
718	Payment	General	What is the average monthly payroll volume?	The Department does not have this information.
719	Payment	General	How many payments are processed currently each month?	The Department does not have this information.
720	Payment	General	What is the average funding amount required per payroll including all employer related costs?	The Department does not have this information.
721	Payment	General	What is the average payroll cost for the CDPAP program per payroll cycle?	The Department does not have this information.
722	Payment	General	Will the PMPM fee be billed directly to the state or to each of the MCOs?	This question is not relevant to the development of a proposal under this RFP.
723	Payment	Section 5.4: Payment (Page 12 of RFP)	How frequently are FFS claims processed- weekly?	Weekly
724	Payment	Section 4.1: Required Fiscal Intermediary Services, Bullet h) (Page 5 of RFP)	Will the selected FI be permitted to negotiate payment rates with MCOs? If so, will the negotiated payment rates include compensation for administrative costs? If so, will the negotiated payment rates include compensation for direct care costs?	The administrative costs will be compensated via the contracted PMPM established under this RFP exclusively.
725	Payment	General	Does the state intend to provide expedited claims processing and what is the expected turn-around time from claims submission date to payment received date?	The Department will work with the awarded Contractor on claims processing.
726	Payment	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet k) (Pages 7-8 of RFP)	Will the Department adjust compensation to the selected FI when the Department establishes guidance, directives, or reporting requirements that add costs that must be borne by the fiscal intermediary?	This question is not relevant to the development of a proposal under this RFP.
727	Payment	Section 5.4: Payment (Page 12 of RFP)	Is the proposed PMPM effective for all 5 years of the contract term or is there a built in annual increase to account for changes in the market? (e.g. inflation, increased labor costs etc.)	The administrative cost PMPM is for all 5 years of the contract.
728	Payment	Section 6.2.F.6: EVV System (Pages 24-25 of RFP)	The RFP asks the bidder to explain how it will ensure claims are correct and timely. However, in section 4.1 is states that the fiscal intermediary shall not engage in activities that are the sole responsibility of the consumer, which includes "Timely approving and attesting to the accuracy of PA time records and transmitting such information to the FI according to the FIs procedures." Is it the bidder or the consumer's responsibility to ensure accuracy of claim data, which is based on time records?	EVV requires that EVV data matches submitted claims.

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729	Peers	Section 4.2: Best Practices, Bullet a) (Page 6 of RFP)	What is a "peer" in the context of CDPAP?	An example of a peer in the context of CDPAP would be a consumer that has been in the program for quite some time who could mentor a new consumer in areas such as how to hire a personal assistant, how to train the personal assistant and other areas where their experience could assist a new consumer best navigate the program. However, the bidder is encouraged to develop its own peer mentoring program and should not use this example as the sole definition of peers.
730	Peers	Section 4.2: Best Practices, Bullet a) (Page 6 of RFP)	Can the Department provide a definition of the term "peer supports, including peer mentoring and counseling" and/or provide examples of same?	See answer to Question #729
731	Peers	Section 4.2: Best Practices, Bullet a) (Page 6 of RFP)	The RFP refers to "peer supports" and "peer mentoring" in paragraph a. Can the Department please provide an example of this better practice to help the consumers and statewide FI?	See answer to Question #729
732	Peers	Section 4.2: Best Practices, Bullet a) (Page 6 of RFP)	Does the fiscal intermediary need to have prior experience providing peer supports, or is it sufficient to describe an intention to utilize peer supports?	See answer to Question #729
733	Peers	Section 4.2: Best Practices, Bullet a) (Page 6 of RFP)	Will the statewide fiscal intermediary be required to provide in-person peer support?	The RFP states that bidders may used creative approaches to assist in the delivery of high quality FI services that best meet the needs of consumers. The best practices identified ion Section 4.2 are not required but will be evaluated.
734	Personal Assistants	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	The RFP states that "fiscal intermediary services **shall not** include fulfillment of the responsibilities of the consumer..." which, in (g) includes "Terminating PAs." If a PA is found guilty of fraud or is otherwise on the ineligible to work list, can the FI terminate the PA?	If the Statewide Fiscal Intermediary becomes aware that a personal assistant is on an exclusion list, they should notify the appropriate authorizing entity for the individual (LDSS/MCO) for further review of the individual's continued eligibility for CDPAP.
735	Personal Assistants	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Is the FI contractor responsible for enrolling personal assistants? If yes, please provide the requirements for the enrollment responsibilities.	It is not clear what is meant by "enrolling personal assistants". Therefore, an answer to this question cannot be given.
736	Personal Assistants	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	May the selected FI establish standards, beyond the statutory and regulatory requirements, for whom a Consumer may hire as a PA?	No.
737	Personal Assistants	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Will Centers for Independent Living be able to perform HR tasks for PAs, including processing hiring paperwork, performing background checks, or any other daily HR processes? This is not a prohibited task in section 5.7	Prohibited subcontractor responsibilities are outlined in Section 5.7 of the RFP.
738	Personal Assistants	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Will Centers for Independent Living be permitted to collect time records for PAs? Section 5.7 prohibits subcontractors from maintaining records but allows them to maintain copies and duplicates.	Prohibited subcontractor responsibilities are outlined in Section 5.7 of the RFP.
739	Personal Assistants	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	If Centers for Independent Living are permitted to collect time records for PAs, will they be required to transmit the time records to the Statewide FI, or can they transmit time records for payroll themselves? If they must submit time records to the Statewide FI, by what means?	Prohibited subcontractor responsibilities are outlined in Section 5.7 of the RFP.
740	Personal Assistants	Section 4.2: Best Practices, Bullet c) (Page 6 of RFP)	May the selected bidder conduct non-face-to-face orientation of a PA without a Consumer's consent?	The RFP states that bidders may used creative approaches to assist in the delivery of high quality FI services that best meet the needs of consumers. The best practices identified in Section 4.2 are not required but will be evaluated.
741	Personal Assistants	Section 4.2: Best Practices, Bullet c) (Page 6 of RFP)	Is the consent of the Consumer necessary to conduct face-to-face orientation for PAs?	The RFP states that bidders may used creative approaches to assist in the delivery of high quality FI services that best meet the needs of consumers. The best practices identified in Section 4.2 are not required but will be evaluated.
742	PMPM	Section 5.4: Payment (Page 12 of RFP)	Should bidders include the provision of leave, health insurance, and other benefits in the administrative Per Member Per Month cost or do such costs get reimbursed as part of the Direct Care Service Costs?	This information is publicly available on the Department's website at https://www.health.ny.gov/health_care/medicaid/redesign/mrt61/2022-09-12_hcw_min_wage_guide.htm

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743	PMPM	Section 5.4: Payment (Page 12 of RFP)	The Department has not included a trend component (18 NYCRR §505.14(h)(7)(ii)(a)(5)) into the rate-setting calculation of the Medicaid fee-for-service administrative rate and direct care rate since at least April 1, 2011. This elimination impacts various rate-setting components within the reimbursement structure, such as the Adjustment for Profit/Surplus, Workers Recruitment and Retention add-on, and other vital rate components. Section 21 of the Health Care Reform Act (HCRA) of 2000 mandated the calculation of the trend factor using proxies based on the Consumer Price Index (CPI) from April 1, 2000, to account for inflation in healthcare costs, provide predictability in budgeting, and maintain fairness in reimbursement rates. Between 2012 and 2022, while the CDPAP Medicaid fee-for-service rate-setting trend component was 0.00%, the CPI showed a cumulative inflation rate of 31.50%. This significant disparity has eroded CDPAP Fiscal Intermediary provider reimbursement rates, jeopardizing financial stability, workforce retention, and quality of care for more than a decade. How will the Department ensure that the trend component is included in the rates for the awarded Statewide Fiscal Intermediary, aligning with economic realities and ensuring fairness, sustainability, and the well-being of all stakeholders in the CDPAP industry?	Administrative costs will be compensated via the PMPM established under this contract.
744	PMPM	Section 5.4: Payment (Page 12 of RFP)	Will MCO's be required to pay the approved PMPM and not pay an amount they choose?	Administrative costs will be compensated via the PMPM established under the contract exclusively.
745	PMPM	Section 6.3: Cost Proposal (Pages 24-25 of RFP)	Can you provide guidance on how to structure the single all-inclusive Per Member Per Month (PMPM) cost in a way that is compliant with the RFP's requirements?	Bidders should reference Section 6.3 of the RFP and Attachment F for this information.
746	PMPM	General	What is the current average PMPM?	https://www.health.ny.gov/facilities/long_term_care/reimbursement/cdpap/fiscal_int_3_tiered_fee_schedule.htm
747	PMPM	Section 5.4: Payment (Page 12 of RFP)	What are the PMPM rates paid to the current vendors who support this service?	https://www.health.ny.gov/facilities/long_term_care/reimbursement/cdpap/fiscal_int_3_tiered_fee_schedule.htm
748	PMPM	Attachment F: Cost Proposal (Page 34 of RFP)	Attachment F requires a single "PMPM to complete all FI Statewide Functions". Are bidders to assume that each year of the 5-year contract has the same PMPM?	See response to Question #727
749	PMPM	Section 5.4: Payment (Page 12 of RFP)	Is there a single PMPM tier that the statewide FI should bill, or are there multiple tiers? If there are multiple tiers, can the Department provide a description?	There is only one PMPM to be proposed for on-going administrative costs of the program.
750	PMPM	Section 5.4: Payment (Page 12 of RFP)	Will there be State-mandated universal service codes for the PMPM tiers? Or will those for FFS be used, and if so, are those codes defined somewhere?	There is only one PMPM to be proposed for on-going administrative costs of the program.
751	PMPM	Section 5.4: Payment (Page 12 of RFP)	The Department wants a single PMPM in the cost proposal. Should this be a blended rate for all consumers and not be broken out by the number of hours the consumer receives per month?	There is only one PMPM to be proposed for on-going administrative costs of the program.
752	PMPM	General	Can you provide the number of individuals receiving Tier 1, Tier 2, and Tier 3 services?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
753	PMPM	Section 6.3: Cost Proposal (Pages 24-25 of RFP)	Section 6.3 Attachment F Should we propose cost of living increases in the PMPM throughout the duration of the contract, or will there be an opportunity to negotiate these increases during the contract period?	The Contractor's proposed PMPM will be effective for the full five (5)-year contract term. There will not be an opportunity to negotiate an increase in the Contractor's PMPM during the resulting contract.
754	PMPM	Section 5.4: Payment (Page 12 of RFP)	Should the administrative PMPM include costs related to implementing best practices?	The proposed PMPM will be an all-inclusive price to complete all FI Statewide Administrative functions through the resulting contract. See Section 5.4 of the RFP.
755	PMPM	Section 4.2: Best Practices (Page 6 of RFP)	What percentage of the PMPM does the state estimate should be represented by utilization of best practices?	This amount would be at the bidder's discretion.
756	PMPM	Section 6.3: Cost Proposal (Pages 24-25 of RFP)	What percent of people are in the tiers that are currently being paid?	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
757	PMPM	Section 5.4: Payment (Page 12 of RFP)	The Department wants a single PMPM in the cost proposal. Should this contain transition costs?	No. See Amendment #3
758	PMPM	Section 5.4: Payment (Page 12 of RFP)	Are transition costs to be included in the submitted PMPM?	No. See Amendment #3

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759	PMPM	Section 5.4: Payment (Page 12 of RFP)	Can the Department provide a detailed timeline and action plan for implementing the corrected direct care regional ceiling for Medicaid fee-for-service direct care reimbursement rates to reflect the current direct care costs as required by the regulation, ensuring accurate calculations for Adjustment for Surplus and Worker Recruitment and Retention (WR&R) components, which will directly impact the financial proposals and operational planning of SFI bidders?	The Department is in compliance with existing rules and regulations
760	PMPM	Section 5.4: Payment (Page 12 of RFP)	Section 5.4 States that the "Contractor will not be reimbursed separately by NYS or any other entity for any Administrative Services outside of its proposed PMPM bid under this RFP." a. Does this apply only to Fee for Service? b. Can the SFI be reimbursed for PMPM in their contracts with MCOs? c. Will the state be paying a PMPM to the MCOs that is then passed through to the SFI?	The Statewide FI will be responsible for all Fiscal Intermediary Administrative Services under the PMPM bid.
761	PMPM	Section 5.4: Payment (Page 12 of RFP)	How will the current funding structure change once the single FI is implemented?	There is only one PMPM to be proposed for administrative costs for the bidder.
762	PMPM	Section 5.4: Payment (Page 12 of RFP)	During the first year of the contract, the Statewide FI will be paid an administrative PMPM based on Attachment F: Cost Proposal. How will contract years 2-5 have the administrative PMPM increase to offset the natural inflation of all costs?	The Contractor's proposed Administrative Costs PMPM will be effective for the full five (5)-year contract term. There will not be an opportunity to negotiate an increase in the Contractor's Administrative Costs PMPM during the resulting contract.
763	PMPM	Section 5.4: Payment (Page 12 of RFP)	The CDPAP regulation (18 NYCRR 505.28) states "…fiscal intermediary administrative costs means the allowable costs incurred by a fiscal intermediary for performance of fiscal intermediary services under section 365-f(4-a) of the Social Services Law" and does not mention the Statewide FI. Please advise.	The RFP outlines the responsibilities of the Statewide Fiscal Intermediary.
764	PMPM	Section 5.4: Payment (Page 12 of RFP)	Can an applicant propose an administrative PMPM that tracks the three-tiered PMPM that is currently in place for FFS?	There is only one PMPM to be proposed for administration of the program.
765	PMPM	Section 5.4: Payment (Page 12 of RFP)	After the first year of the contract, how will contract years 2-5 have the administrative PMPM increase to offset the natural inflation of all costs?	The Contractor's proposed PMPM will be effective for the full five (5)-year contract term. There will not be an opportunity to negotiate an increase in the Contractor's PMPM during the resulting contract.
766	PMPM	Section 5.4: Payment (Page 12 of RFP)	Can the Department of Health provide data on the current average PMPM administrative reimbursement for fiscal intermediaries based on recent cost reports, as a PMPM specifically for Medicaid Managed Care Contracts?	The Department will not provide this information
767	PMPM	Section 5.4: Payment (Page 12 of RFP)	If rates cannot be negotiated and is determined by the SFI, will there be any incentives with the PMPM model as I am sure there will be particular metrics that need to be met, correct?	This question is not relevant to the development of a proposal under this RFP.
768	PMPM	Section 5.4: Payment (Page 12 of RFP)	How should the cost proposal account for potential variations in administrative costs across different regions?	The Contractor's proposed PMPM will be effective for the full five (5)-year contract term. There will not be an opportunity to negotiate an increase in the Contractor's PMPM during the resulting contract.
769	PMPM	Section 5.4: Payment (Page 12 of RFP)	Will the awarded SFI be required to accept payment at their PMPM bid price for the entire term of the contract? a. Will the contract be awarded for a 5-year term, or will DOH consider a shorter or longer term? b. If DOH will consider shorter or longer contract terms, where in the Cost or Technical proposal can a bidder indicate that the PMPM bid price is dependent on a particular term duration?	All bids will be considered for a 5 year term as outlined in the RFP
770	PMPM	Section 5.4: Payment (Page 12 of RFP)	Is there a single PMPM tier that the statewide FI should bill, or are there multiple tiers? If there are multiple tiers, can the Department provide a description?	There is only one PMPM to be proposed for on-going administrative costs of the program.
771	PMPM	Section 5.4: Payment (Page 12 of RFP)	Will there be State-mandated universal service codes for the PMPM tiers? Or will those for FFS be used, and if so, are those codes defined somewhere?	There is only one PMPM to be proposed for on-going administrative costs of the program.
772	PMPM	Section 5.4: Payment (Page 12 of RFP)	What happens when a member changes providers mid-month? How will PMPM be billed?	There is only one PMPM to be proposed for on-going administrative costs of the program.
773	PMPM	Section 5.4: Payment (Page 12 of RFP)	What happens when an authorization changes mid-month – for example, hours increase or decrease – what tier should the provider bill?	There is only one PMPM to be proposed for on-going administrative costs of the program.
774	PMPM	Section 5.4: Payment (Page 12 of RFP)	Should the claim for PMPM be billed on the first of the month, the last of the month, or is the date of claim irrelevant?	This question is not relevant to the development of a proposal under this RFP. Specific billing procedures will be determined after contract execution.

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775	PMPM	Section 5.4: Payment (Page 12 of RFP)	Are providers meant to bill the payer for the PMPM for the month in arrears/prior month or the month forthcoming? If done in arrears on actual hours, calculating tiers would seem to be more straightforward.	This question is unclear and thus will not be answered.
776	PMPM	Section 5.4: Payment (Page 12 of RFP)	The transition to the PMPM model requires a bit of precision when it comes to forecasting. If the DOH is only allowing an estimation of our proposed PMPM amount that we cannot go over, what is than the resolve if more individuals are in need of assistance?	Since reimbursement is being done on a PMPM basis, increased utilization of individuals would by its very nature increase contractor reimbursement.
777	PMPM	Section 5.4: Payment (Page 12 of RFP)	Are all costs relative to the subcontractor included in the PMPM?	Yes.
778	PMPM	Section 5.4: Payment (Page 12 of RFP)	Will there be opportunities to reconcile the PMPM set at the start of the contract? If additional requirements are imposed on the FI subsequent to the submission of the bid, will there be an opportunity to adjust?	No, the PMPM costs submitted at the time of the proposal submission will be the contracted bid amount.
779	PMPM	Section 5.4: Payment (Page 12 of RFP)	Can the Administrative cost proposal include reasonable increases to be implemented during the 5 year term?	The Contractor's proposed Administrative Costs PMPM will be effective for the full five (5)-year contract term. There will not be an opportunity to negotiate an increase in the Contractor's Administrative Costs PMPM during the resulting contract.
780	PMPM	Section 5.4: Payment (Page 12 of RFP)	Current New York State regulations define a three-tiered administrative rate structure for Fee-For-Service payments. May a contractor propose a PMPM greater, less, or different from the three-tiered administrative rate structure?	Yes.
781	PMPM	Section 5.4: Payment (Page 12 of RFP)	The Department has recently announced that MMC payments for administrative services will be governed by the same three-tiered administrative structure as is currently applicable to Fee-For-Service payments. May a contractor propose a PMPM greater, less, or different from the three-tiered administrative rate structure?	Yes.
782	PMPM	Section 6.3: Cost Proposal (Pages 24-25 of RFP)	Section 6.3 and Attachment F, "Cost Proposal", appear to contemplate ongoing operational administrative costs. Have you considered bidders' separately accounting for the substantial costs involved in transitioning to the single FI?	See Amendment #3 for revisions to the Cost Proposal.
783	PMPM	Section 6.3: Cost Proposal (Pages 24-25 of RFP)	We assume the PMPM Fee will be based on the actual number of members in a given month." How and by whom, are the actual number of members determined each month?	The Statewide Fiscal Intermediary will be reimbursed based on the number of CDPAP consumers it is serving in a given month.
784	PMPM	Section 6.3: Cost Proposal (Pages 24-25 of RFP)	Please provide additional information regarding the demographics, backgrounds, needs of consumers, including direct care hours (actual/authorized) per month per consumer to enable applicants to more efficiently calculate the Administrative PMPM.	The Department will not provide this information
785	PMPM	Section 6.3: Cost Proposal (Pages 24-25 of RFP)	Is it anticipated that subcontractors will be paid by the Statewide FI as part of the Administrative Costs?	Yes.
786	PMPM	Attachment F: Cost Proposal (Page 34 of RFP)	Will the PMPM be based on enrolled consumers or active service?	The PMPM will be based on the enrollees receiving CDPA services
787	PMPM	General	If the Department is using a contractor what is their current PMPM rate.	The Department does not currently have a contractor for fiscal intermediary services.
788	Post Award	General	Should the agency receive an extension to provide those services moving forward; will the current list of individuals remain intact? Or will there be a new system in which the entire population, as a whole, be redistributed evenly amongst the list of other providers?	CDPAP will remain as is until the transition to the Statewide Fiscal Intermediary is complete.
789	Post Award	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet c) (Page 8 of RFP)	Will contact information to individuals in the statewide FI organizational chart be provided?	Information on how an individual may contact the Statewide Fiscal Intermediary will be available through the Local Departments of Social Services and managed care plans.
790	Post Award	Title Page (Page 1 of RFP)	Permissible Subject Matter Contact - Is there a process pursuant to which an applicant that does not receive a contract award can receive a "debriefing" and can appeal the determination? Page 1 states that Mr. Lewandowski is the contact for "debriefings".	No, debriefings will not be offered for bidders who did not receive an award from this RFP. Please see Amendment #1 to the RFP.
791	Post Award	Section 1.0: Calendar of Events (Page 3 of RFP)	Are all bids subject to being entered into the public record, and when will they be available to the public?	No, the bids received in response to this RFP will not be made public.
792	Post Award	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet c) (Page 8 of RFP)	Will the organizational chart of the statewide FI be made available to the public?	An executed contract, which would include the organizational chart, could be requested through the Freedom of Information Law. In addition, the Department may post certain contact information for the Statewide Fiscal Intermediary on its website.

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793	Post Contract Transition	Section 4.10: Transition Requirements (Page 11 of RFP)	What are the specific data transfer and documentation requirements for the transition period described in Section 4.10?	See Amendment #3.
794	Post Contract Transition	Section 4.10: Transition Requirements (Page 11 of RFP)	These transition requirements include the transfer of information that may be covered by HIPAA and its amendments. How can a bidder be required to commit to transferring all information, as there may be Consumers who refuse to give consent?	See Amendment #3.
795	Post Contract Transition	Section 4.10: Transition Requirements (Page 11 of RFP)	What are the key components and timeline expectations for the transition plan to ensure a smooth transfer of responsibilities and data?	See Amendment #3.
796	Post Contract Transition	Section 4.10: Transition Requirements (Page 11 of RFP)	Why must the plan and documentation for transition be submitted at least 6 months prior to the transition	See Amendment #3.
797	Proposal Submission	Section 5.3: Right to Modify RFP (Page 12 of RFP)	5.3 Right to Modify RFP, specifically, "If the bidder discovers any ambiguity, conflict, discrepancy, omission, or other error in this RFP, the bidder shall immediately notify DOH of such error in writing at OHIPContracts@health.ny.gov and request clarification or modification of the document." Question: What is the timeline to submit such discovery? Is it prior to the submission date for the RFP?	A notification would be required to be submitted prior to the Deadline of Submission of Proposals.
798	Proposal Submission	Attachment 2: No-Bid Form	This is a No Bid form. Does this form need to be submitted? It does not seem like the structure of the procurement would require this form to be submitted.	Bidders do not need to submit the No-Bid Form.
799	Proposal Submission	Section 2.2: Other Important NYS Contracting Information for Bidders (Pages 3-4 of RFP)	For attachment 7, 1.B. what "name, address, telephone number, and email address of the Bidder's Primary Contact with DOH" should be used?	Bidders should include their main/primary contact in relation to their submitted proposal under this RFP.
800	Proposal Submission	Section 6.2.A: Title Page (Pages 20 of RFP)	How will an entity provide a NYS Tax ID & NYS Dept of State ID if they are not currently operating within New York State?	Entities who do not currently possess a NYS TAX ID or NYS Dept of State ID, may omit them on the Title Page.
801	Proposal Submission	Section 6.2.A: Title Page (Pages 20 of RFP)	Must an applying entity for the single statewide Fiscal Intermediary establish both a NYS Tax ID & Dept of State ID in order to be eligible?	See response to Question #800. A NYS Tax ID and Dept of State ID are not required at the time of bid, but will be required for the awarded contractor prior to the contract start date.
802	Proposal Submission	Section 2.2: Other Important NYS Contracting Information for Bidders (Pages 3-4 of RFP)	In the event that any qualifications or exceptions are accepted, will the time for response to the RFP be extended?	No.
803	Proposal Submission	Section 6.0: Proposal Content (Pages 17-18 of RFP)	Is there a page limit for any of the responses in any of the three components – administrative, technical, and cost?	No.
804	Proposal Submission	Attachment A: Bidder Document Checklist (Page 28 of RFP)	Are bidders required to include Attachment A Offer Document Checklist in their submission?	No.
805	Proposal Submission	Section 5.8: DOH's Reserved Rights (Page 16 of RFP)	The RFP states that the Department maintains the ability to "Negotiate with the bidder selected to be the awarded Statewide FI within the scope of the RFP in the best interests of the state." Does this mean that bidders are not required to submit their "last and best" offer in terms of an administrative PMPM?	No. Bidders should submit their Cost Proposal accordance to the requirements set forth in Section 6.3 of the RFP and Attachment F.
806	Proposal Submission	Section 5.8: DOH's Reserved Rights (Page 16 of RFP)	The RFP states that the Department maintains the ability to "Seek clarifications and revisions of bids." Does this include an ability by the Department to request that a bidder revise their PMPM administrative cost post-submission?	No. See Section 5.8, Bullet 16 of the RFP.
807	Proposal Submission	Section 5.8: DOH's Reserved Rights (Page 16 of RFP)	The RFP states that the Department maintains the ability to "Seek clarifications and revisions of bids." The RFP also states that the Department may "Utilize any and all ideas submitted in the bids received." When taken together, does this mean that the Department may request that Bidder A revise its bid to incorporate provisions from other bids that would otherwise mean that the other bids would achieve a higher score than Bidder A?	No. See Section 5.8, Bullet 16 of the RFP.
808	Proposal Submission	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet b) (Page 8 of RFP)	What are the qualifications of administrative staff and how will it be measured by DOH?	The proposal should outline the qualifications of the bidder's administrative staff to ensure the responsibilities of the RFP will be delivered.
809	Proposal Submission	Section 5.2: Questions (page 12 of RFP) and Section 5.3: Right to Modify RFP (Page 12 of RFP)	If further clarifications are needed after the submission of written questions, what is the process for obtaining additional information?	There is no additional opportunity for questions and answers.

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810	Proposal Submission	Section 5.8: DOH's Reserved Rights (Page 16 of RFP)	The RFP states that the Department maintains the ability to "Conduct contract negotiations with the next responsible bidder, should the Department be unsuccessful in negotiating with the selected bidder." Does this mean that bidders are expected to lower their PMPM after winning the contract in order to successfully contract?	No
811	Proposal Submission	Section 6.1.8 State Finance Law Consultant Disclose Provisions (Page 19 of RFP)	Will DOH provide instructions on how to complete these forms?	See Section 6.1.8 of the RFP and the links contained within that section for instructions related to the State Consultant Services Form A and B.
812	Proposal Submission	Section 6.1.9: Sales and Compensating Use Tax Certification (Tax Law, § 5-a) (Pages 19-20 of RFP)	Will DOH provide instructions on how to complete ST-220 CA? The instructions are currently missing.	See Section 6.1.9 of the RFP and the links contained within that section for instructions related to the completing the ST-220-CA form.
813	Proposal Submission	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	What documentation will be needed to demonstrate capability to perform the full spectrum of New York State fiscal intermediary services?	See Section 6.2.D of the RFP.
814	Proposal Submission	Section 7.0: Proposal Submission (Page 25 of RFP)	For the response submission, please provide the file size limitation for the email submission.	The size limit for each email attachment is contingent upon the bidder's email server. A bidder is able to submit multiple emails with split attachments in order to limit attachment sizes.
815	Proposal Submission	Section 5.10: Encouraging Use of New York Businesses in Contract Performance (Page 17 of RFP)	Section 5.10 states that "bidders for this contract for commodities, services or technology are strongly encouraged and expected to consider New York State businesses in the fulfillment of the requirements of the contract." How will DOH measure whether and to what degree bidders have considered New York State businesses relative to out-of-state businesses? How will DOH "strongly encourage" such consideration?	This information will not be shared with the bidding community. The Department encourages such considerations through the submission of Attachment 6: Encouraging Use of New York State Businesses in Contract Performance. See Section 6.1.4 of the RFP.
816	Proposal Submission	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	Section 4.5 of the RFP provides that the awarded contractor shall have and maintain an effective organizational structure with qualified administrative staff. How many administrative staff is the awarded contractor anticipated by the Department to maintain?	This is at the bidder's discretion to ensure all program responsibilities and expectations can be met.
817	Proposal Submission	General	Is there a percentage cap of the population to be served between ILS and the MCOs versus the private entities/subcontractors (FI)? For example 30% of the population goes to ILS, 20% MCO, 50% Private Entities?	This question is not clear and therefore cannot be answered.
818	Proposal Submission	Section 6.1.8 State Finance Law Consultant Disclose Provisions (Page 19 of RFP)	Does this requirement apply when the Statewide FI procures consultants for general management consulting on projects, such as Compensation Studies or Operations and Project Management?	Yes, this will be required of the successful bidder as stated within Section 6.1.8 of the RFP.
819	Proposal Submission	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet a) (Page 8 of RFP)	What is the definition of "entities" in the context of the RFP?	With regard to RFP Section 4.5.a, an entity may include managed care plans, Local Departments of Social Services and other entities as needed to effectuate the responsibilities under the contract.
820	Proposal Submission	Section 5.4: Payment (Page 12 of RFP)	Would the Department be willing to revise the Cost Proposal requirements to distinguish between program implementation costs and ongoing support?	See Amendment #3 for revisions to the Cost Proposal. No other revisions will be made.
821	Proposal Submission	Section 5.7: Subcontracting (Pages 15-16 of RFP)	The RFP says DOH must approve any subcontracting arrangements and can make a contingent award pending DOH review and approval of subcontracting agreements. If one or more a subcontracting arrangements is critical to the cost and operational component of the bid and DOH does not ultimately approve the subcontract, what measures can a bidder take to secure substitute subcontractors? Are there parameters within which the bidder must adhere in order to maintain the award? What if DOH does not approve the subcontractor and there are no comparable subcontractors that can perform the services either by price or competency?	This question is not relevant to the development of a proposal under this RFP.
822	Proposal Submission	Section 5.8: DOH's Reserved Rights (Page 16 of RFP)	How will the Department handle situations where market conditions change significantly within the specified 365-day period?	This question is not clear and therefore cannot be answered.

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823	Proposal Submission	Section 6.2.E: Program Specific Certifications and Attestations (Pages 21-22 of RFP)	The RFP states that bidders must attest "they will work cooperatively with Department of Health, Office of the State Comptroller (OSC), OMIG, the New York State Office of the Attorney General, the Department of Health and Human Services (DHHS), the DHHS Office of Inspector General (OIG), and their designated representatives." Is the bidder not required to cooperate with the NYS Department of Labor or United States Department of Labor?	The selected bidder will be responsible for complying with all applicable laws, rules, and regulations, both state and federal and will be subject to the corresponding applicable sanctions and penalties. The selected bidder will be expected to consult with its advisors to determine legal compliance.
824	Proposal Submission	Section 6.2.F: Technical Proposal Narrative/Executive Summary (Pages 22-24 of RFP)	Upon our review of RFP #20524 we have identified a possible discrepancy in the RFP. Pursuant to the guidelines in section 5.3, we request clarification related to Section 6. F. Technical Proposal Narrative/Executive Summary. This section does not include all the requirements of the Scope of Work (Section 4). Are the SOW sections that have been omitted from the Technical Proposal Narrative intentional because these are requirements of the FI, but bidders do not need to speak to these requirements in the technical response? Or does the Department request a formal response? If so, where in the Technical Response document would the Department prefer content responsive to these sections be addressed?: 4.3 Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements; 4.4 Statewide Fiscal Intermediary Compliance Requirements; 4.8 Information Technology Requirements; 4.9 Privacy, Security & Confidentiality Requirements; 4.10 Transition Requirements	As stated in Section 6.2.F, "The technical proposal should provide satisfactory evidence of the bidder's ability to meet, and expressly respond to, each requirement of and information requested in this RFP in Section 4.0.". As such, bidders should include responses in the format requested in Section 6.2, while addressing all aspects of Section 4.0 of the RFP.
825	Proposal Submission	Section 6.2.F.1: Required Fiscal Intermediary Scope of Work (Pages 22-23 of RFP)	The RFP asks bidders to explain their ability and experience serving members with disabilities. What types of disabilities is the state looking for experience serving?	All types
826	Proposal Submission	Section 6.2.F.1: Required Fiscal Intermediary Scope of Work (Pages 22-23 of RFP)	The RFP asks bidders to explain their ability and experience serving members with disabilities. In section 4.0, Fiscal Intermediary Scope of Work, the RFP speaks of the need for experience serving people with disabilities and seniors. Why do prospective bidders not need to explain their ability and experience with serving a senior population?	See Amendment #3 to the RFP.
827	Proposal Submission	Section 6.2.F.1: Required Fiscal Intermediary Scope of Work (Pages 22-23 of RFP)	For Item F.1.d), can the Department offer any additional guidance related to adult use of marijuana and compliance with this regulation?	10 NYCRR 766.11(c) states: "that the health status of all new personnel is assessed and documented prior to assuming patient care duties. The assessment shall be of sufficient scope that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior;"
828	Proposal Submission	Section 6.2.F.1: Required Fiscal Intermediary Scope of Work (Pages 22-23 of RFP)	For Item F.1.j), are there any "additional services" that DOH anticipates it may require so that Bidders can evaluate the potential cost impact in their responses?	Not at this time.
829	Rate Setting Regions	Section 4.0: Scope of Work, Third Bullet (Page 5 of RFP)	The RFP states that the single statewide FI will be responsible for "Subcontracting with at least one entity per NYS DOH MLTC rate setting region, as seen in Attachment D, that has a proven record of delivering services to individuals with disabilities and the senior population and has been providing fiscal intermediary services since January 1, 2012, or earlier." Please clarify whether this is referencing 3 entities in total, one for each region, or one entity per County listed in Attachment D? How will the FI know whether the entity has a proven track record? Can the Department provide this list?	There are four rate setting regions. There must be at least one subcontractor in each region. The bidder would make the decision on their track record based on outreach to potential subcontractors. The Department will not provide a list.

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830	Rate Setting Regions	Section 4.0: Scope of Work (Page 5 of RFP)	The RFP states that the successful FI is required to subcontract with "at least one entity per NYS DOH MLTC rate setting region..." Is the subcontracted entity required to be able to provide services across the entire rate setting region, or is the bidder able to subcontract with an entity that is only going to provide those services in one portion of the NYS DOH MLTC rate setting region? For example, one NYS DOH MLTC rate setting region includes Erie, Onondaga, and Albany counties. Can the bidder contract with an entity that will only provide subcontracted services in Erie and not in Albany or Onondaga counties?	There are four rate setting regions. There must be at least one subcontractor in each region. The bidder would make the decision on their track record based on outreach to potential subcontractors. The Department will not provide a list.
831	Rate Setting Regions	Section 4.0: Scope of Work (Page 5 of RFP)	The RFP states that the bidder must subcontract with "at least one entity per NYS DOH MLTC rate setting region...and has been providing services since at least January 1, 2012." Is the bidder required to limit the reach of subcontractors to counties that the subcontractor had been providing services to continuously since January 1, 2012?	No.
832	Rate Setting Regions	Section 4.0: Scope of Work (Page 5 of RFP)	The RFP states that the bidder must subcontract with "at least one entity per NYS DOH MLTC rate setting region ...that has a proven record of delivering services to people with disabilities and the senior population and has been providing services since at least January 1, 2012." Is the bidder required to contract with more than one entity in total if the entity with which it subcontracts will provide services across every NYS DOH MLTC rate setting region?	The bidder must subcontract with at least one entity in each rate setting region.
833	Rate Setting Regions	Section 4.0: Scope of Work (Page 5 of RFP)	What is meant by having a presence in a rate-setting region?	The bidder must subcontract with at least one entity in each rate setting region.
834	Registration	Section 2.1: Background Information (Page 3 of RFP)	Will centers for independent living be required to register with the DOH before billing for services as required subcontractors?	Only the Statewide Fiscal Intermediary will bill the State for fiscal intermediary services.
835	Registration	Section 2.1: Background Information (Page 3 of RFP)	The statute (SOS § 365-f) specifies that subcontractors must register with the Department of Health within 30 days of selection, while the regulation (18 NYCRR 505.28) does not include any provisions about subcontractor registration. What are the specific registration and reporting requirements for subcontractors under this RFP, and how will compliance be monitored?	The implementation and specifics of the subcontractor registration requirement are still being determined. The registration process should not be factored into the proposal submission.
836	Registration	Section 2.1: Background Information (Page 3 of RFP)	Section 2.1 states, "…all subcontractors of the awarded Statewide Fiscal Intermediary are required to register with the Department within 30 days of being selected as a subcontractor." Because service centers for independent living are designated as entities that the Statewide FI must subcontract with, are they required to register? If so, what is the process to register?	See answer to Question #835
837	Registration	Section 2.1: Background Information (Page 3 of RFP)	If service centers for independent living are required to register, what specific documentation or information will they have to provide during the registration process?	See answer to Question #835
838	Registration	Section 2.1: Background Information (Page 3 of RFP)	Do subcontractors have to wait until their contract is fully executed to register? If so, what prevents the SFI from deliberately delaying these required contracts?	See answer to Question #835
839	Registration	Section 2.1: Background Information (Page 3 of RFP)	Will there be a public registry of subcontractors? If so, will centers for independent living have to register as required subcontractors?	See answer to Question #835
840	Registration	Section 2.1: Background Information (Page 3 of RFP)	What will the DOH registration process for subcontractors consist of?	See answer to Question #835
841	Registration	Section 4.0: Scope of Work, Third Bullet (Page 5 of RFP)	Section 4.0 bullet two states that the awarded Statewide Fiscal Intermediary will be responsible for "subcontracting to facilitate the delivery of fiscal intermediary services to each entity that is a service center for independent living under section 1121 of the New York State Education Law ("EDN") and has been providing fiscal intermediary services since January 1, 2024, or earlier;" and section 2.1 paragraph three states that "all subcontractors of the awarded Statewide Fiscal Intermediary are required to register with the Department within 30 days of being selected as a subcontractor." Does this mean that each service center for independent living will be required to register within 30 days of the Statewide FI contract being approved by the Commissioner of Health?	See answer to Question #835

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842	Registration	Section 2.1: Background Information (Page 3 of RFP)	What is the form of registration for subcontractors? Is the form of registration for subcontractors different for independent living center subcontractors?	The implementation and specifics of the subcontractor registrations requirement are still being determined.
843	Reporting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	What performance metrics will be used to evaluate the SFI compliance & performance over the 5 years?	This question is not relevant to the development of a proposal under this RFP. Reporting requirements will be determined between the Department and the Statewide Fiscal Intermediary at the time of contract execution.
844	Reporting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	What metrics will be used to evaluate the SFI compliance & performance over the 5 year period and can an agreement be terminated before the end of the 5 year period? If so, for what reasons?	See answer to Question #843
845	Reporting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	The RFP states that the term of the contract is subject to "successful contractor performance." What metrics will be used to determine whether or not the contracted entity is meeting this requirement?	See answer to Question #843
846	Reporting	Section 4.2: Best Practices, Paragraph 1 (Page 6 of RFP)	How will the Department of Health quantify and interpret the quality of fiscal intermediary services?	See answer to Question #843
847	Reporting	Section 4.2: Best Practices, Paragraph 3 (Page 6 of RFP)	What metrics will DOH use to determine the "quality" of FI services?	See answer to Question #843
848	Reporting	Section 4.2: Best Practices (Page 6 of RFP)	What are the variables suggesting “high-quality FI services”?	See answer to Question #843
849	Reporting	Section 4.2: Best Practices (Page 6 of RFP)	Who determines what is "high-quality FI services"?	See answer to Question #843
850	Reporting	Section 4.2: Best Practices (Page 6 of RFP)	Will the suggested "high-quality FI services" be provided by the statewide FI or by any subcontractors?	See answer to Question #843
851	Reporting	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	Will the Statewide FI be required to report to DOH regarding wait times, call abandonment rates, etc. on the customer service phone line?	See answer to Question #843
852	Reporting	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	Will the Statewide FI be required to report on the length of time it takes to enroll a new PA to a case?	See answer to Question #843
853	Reporting	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP) and Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	What are the Department’s expectations for handling ongoing audits and compliance reporting, especially in terms of frequency and detail?	See answer to Question #843
854	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	What specific quality measures and reporting requirements will be expected from the awarded Statewide Fiscal Intermediary (FI), as outlined in Section 4.7 of the RFP?	See answer to Question #843
855	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	Will the Quality Management Plan be made available to the public?	See answer to Question #843
856	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	When will DOH announce the factors/variables of what is included in Quality Management Plan reports?	See answer to Question #843
857	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	Will the public have an opportunity to offer additional factors of what constitutes quality FI services?	See answer to Question #843
858	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	Will consumers have an opportunity to comment on that Quality Management Plan reports?	See answer to Question #843

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859	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	What should be included within the Quality Management Plan?	See answer to Question #843
860	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	What specific quality measures and performance metrics will the Department utilize to assess and monitor the effectiveness and quality of services?	See answer to Question #843
861	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	What measures will be evaluated in the Quality Management Plan?	See answer to Question #843
862	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	Will the Department require the Statewide FI to report (any pay) their gross receipts tax (GRT) on a monthly basis? Has the Department conducted a recent comprehensive reconciliation of all existing Fiscal Intermediaries enrolled in CDPAP, utilizing data from, for example, county LDSS's and Medicaid Managed Care Plan contracts to ascertain/identify the Fiscal Intermediary entities, or Cost Reporting data/information, to ensure compliance with the state's GRT requirements under the Health Facility Cash Assessment Program (HFCAP) since its inception in 2002? Given that GRT significantly contributes to the State's fiscal health, such a reconciliation could uncover substantial missed funds, potentially amounting to millions (retrospective and prospective impact), thereby contributing to the state's overall savings goals?	See answer to Question #843
863	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	What are the reporting requirements for the Statewide FI concerning quality monitoring and consumer satisfaction?	See answer to Question #843
864	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	The RFP outlines compliance and quality assurance requirements for the Statewide Fiscal Intermediary and its subcontractors. How will the Department ensure that these requirements are uniformly enforced across all subcontractors, especially considering the historical challenges and varying capabilities of different entities?	See answer to Question #843
865	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	What are the minimum acceptable standards for the quality and effectiveness of the Statewide FI?	See answer to Question #843
866	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	How frequently will the awarded FI need to submit compliance reports, and what specific content will these reports need to include, as outlined in Section 4.7 of the RFP?	See answer to Question #843
867	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	Is the consumer satisfaction survey required only once in the contract term? If not, how many times?	See answer to Question #843
868	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	The RFP states that "The awarded Statewide FI will be required to submit a Quality Management Plan." Please define quality as it relates to the delivery of fiscal intermediary services.	See answer to Question #843
869	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements, Paragraph 1 (Page 9 of RFP)	What components should be included within the Quality Management Plan as stipulated by the Department?	See answer to Question #843
870	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements, Paragraph 1 (Page 9 of RFP)	What should be included within the specified "Quality Management Plan?"	See answer to Question #843
871	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements, Paragraph 1 (Page 9 of RFP)	What specific quality measures and performance metrics will the Department utilize to assess and monitor the effectiveness and quality of services?	See answer to Question #843

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New York State Fiscal Intermediary Services
Questions and Answers - August 7, 2024

Number	Subject	Corresponding RFP Section	Question	Answer
872	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	The RFP states that "the awarded Statewide FI shall submit reports to the Department that include, but are not limited to, quality measures and other data to assist the Department, consumers, LDSS and MCOs with evaluating the effectiveness and quality of services provided by the FI under this contract and their impact on the overall quality and effectiveness of CDPAP." Please define what quality measures the Statewide Fiscal Intermediary will be measured by as they relate to the "effectiveness and quality of services provided by the FI" as such information is critical to bidders in determining what to factor into programmatic administrative costs.	See answer to Question #843
873	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	What are bidders being asked to commit to with respect to quality monitoring and reporting requirements, as the language of this section suggests that the Department does not know what it will be looking for?	See answer to Question #843
874	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	Will the Department represent that the data to be collected and reported, the format, and the frequency of the reports will be commercially reasonable and not financially burdensome?	See answer to Question #843
875	Reporting	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP) and Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	What specific metrics or KPIs are expected to be included in the Quality Management Plan as part of the reporting requirements?	See answer to Question #843
876	RFP	Section 5.8: DOH's Reserved Rights (Page 16 of RFP)	What specific conduct or bid non-conformities would lead to disqualification?	Bidders who do not meet the Minimum Qualifications as identified in Section 3.1 of the RFP, or fail to adhere to the proposal requirements stated within Section 6.0 or Section 7.0, including any applicable attachments, may be disqualified.
877	RFP	Section 5.8: DOH's Reserved Rights (Page 16 of RFP)	The RFP states that the Department maintains the right to "Disqualify any bidders whose conduct, and/or bid fails to conform to the requirements of the RFP." Please elaborate on what conduct would allow the Department to disqualify a bidder.	See response to Question #877
878	RFP	Section 5.8: DOH's Reserved Rights (Page 16 of RFP)	What criteria will be used to justify the rejection of all bids? How will the decision to reject all bids be communicated to bidders?	See response to Question #877
879	RFP	Section 5.8: DOH's Reserved Rights (Page 16 of RFP)	How will the Department ensure transparency and fairness in the disqualification process to avoid potential disputes? If disputes arise, how will they be resolved?	This question is not relevant to the development of a proposal under this RFP. See also answer to Question #919.
880	RFP	Section 1.0: Calendar of Events (Page 3 of RFP)	The Department of Health website now states that it will post responses to written questions on or about July 13, 2024. However, the text of the RFP still references that responses will be posted by July 19, 2024. Which date is correct?	The RFP has been amended to a posting date of August 14, 2024.
881	RFP	Section 1.0: Calendar of Events (Page 3 of RFP)	Will DOH allow for another round or accept follow up questions and answers? Additional clarification and guidance from DOH may be needed after the first round of questions and answers for bidders to work with other organizations to develop adequate bids that can support the successful transition of 246,000 consumers from their current FIs to a single statewide FI.	No, the Department will not allow for another round of questions and answers.
882	RFP	Section 1.0: Calendar of Events (Page 3 of RFP)	A Bidder's Conference is not listed or posted. Will the Department be hosting a Bidder's Conference?	No, the Department will not be hosting a Bidder's Conference for this RFP.
883	RFP	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Does the Department of Health plan to hold a bidder's conference for potential Statewide FIs to meet with potential subcontractors?	No.
884	RFP	Section 5.8: DOH's Reserved Rights (Page 16 of RFP)	The RFP states that the Department maintains the right to "Reject and or all bids in response to the RFP." Does this right extend to disqualification without cause?	No.
885	RFP	Section 8.2: Submission Review (Page 26 of RFP)	Will there be any process opportunity for large CDPA providers to express concerns BEFORE the final SFI selection is made?	No.
886	RFP	Section 5.8: DOH's Reserved Rights (Page 16 of RFP)	The RFP states that the Department maintains the right to "Make an award under this proposal, in whole or in part." What would an award in part look like?	See Amendment #3 to the RFP.
887	RFP	Section 5.8: DOH's Reserved Rights (Page 16 of RFP)	The RFP states that the Department maintains the ability to "Seek clarifications and revisions of bids." Please clarify what aspects of a bid the Department may seek revision to.	See Section 5.8.16 of the RFP.

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888	RFP	Section 1.0: Calendar of Events (Page 3 of RFP)	How was the timeline and award date for this RFP determined?	The Department did not include an anticipated date for notification of an award resulting from this RFP. However, the anticipated contract start date was based on the anticipated amount of time necessary for the Department to conduct evaluations of the bids received and obtain internal approvals of the resulting contract.
889	RFP	Section 2.2: Other Important NYS Contracting Information for Bidders (Pages 3-4 of RFP	This section notes that " "Any amendments DOH makes to the RFP as a result of questions and answers will be publicized on the DOH web site and will be available and applicable to all bidders equally." How and when will all stakeholders be notified of amendments to the RFP based on bidder questions?	The Department will notify prospective bidders via email of any amendments to the RFP. Bidders would be notified once any amendments are posted publicly.
890	RFP	Section 2.2: Other Important NYS Contracting Information for Bidders (Pages 3-4 of RFP)	In the event that any qualifications or exceptions are accepted, will they be made available to all prospective bidders?	Yes. See response to Question #890.
891	RFP	Section 2.2: Other Important NYS Contracting Information for Bidders (Pages 3-4 of RFP)	Will the Department of Health make available to all prospective bidders any qualifications or exceptions proposed by a bidder to the RFP?	Yes. Any such instances are included as questions within this Questions and Answer document.
892	RFP	Section 2.1: Background Information (Page 3 of RFP)	In the 3rd paragraph it mentions "...and other appropriate long term care programs offering CDPAS services ". Is there a list of those programs or a list of any potential programs?	No.
893	RFP	Section 2.1: Background Information (Page 3 of RFP)	Please describe/define "the other appropriate long term care service programs" offering CDPAS?	The Department does not have this definition at this time.
894	RFP	Section 5.8: DOH's Reserved Rights (Page 16 of RFP)	The RFP states that the Department maintains the ability to "Waive any requirements that are not material." Please elaborate on what aspects of the RFP are and are not material and therefore may be waived.	This question is not relevant to the development of a proposal under this RFP.
895	RFP	Section 5.8: DOH's Reserved Rights (Page 16 of RFP	What is meant by "non-material specifications"? Additionally, is the DOH required to make eliminations under Section 5.8 prior to the Deadline for Submission of Proposals? What types of eliminations are permissible? How would notice of eliminations be provided to bidders? How would bidders be able to bid if the requirements change?	This question is not relevant to the development of a proposal under this RFP.
896	RFP	Section 5.12: Intellectual Property (Page 17 of RFP)	Is the DOH absorption of intellectual property limited to new technologies subsequent to the contract, or does it include existing technologies brought to the contract by either the Statewide FI or its subcontractors?	This provision is specific to new technologies or work product created pursuant to the agreement. See Section 5.12 of the RFP.
897	RFP	Section 5.12: Intellectual Property (Page 17 of RFP)	Is the Department amenable to a SaaS solution and if so, does the Department agree that the SaaS solution, along with any enhancements not specifically paid for by the Department, will remain the property of the Contractor?	The Department reserves the right to negotiate terms of the contract that are non-material in nature with the contract awardee, within the scope of the RFP and in the best interests of New York State. Nonetheless, bidders must be fully prepared to accept all of the terms and conditions set forth in the RFP, without modification, should the Department determine that that constitutes the best interests of New York State.
898	RFP	Section 5.12: Intellectual Property (Page 17 of RFP)	What is "work product" under this agreement?	The RFP does not specifically define the meaning of intellectual property for purposes of this opportunity, but respondents may interpret this language as using the commonly understood industry term.
899	Scope of Work	Section 4.0: Scope of Work, Paragraph 1 (Page 5 of RFP)	The statute (SOS § 365-f) specifies that delegated fiscal intermediary services may include assisting consumers with navigation of the program by providing individual consumer assistance and support, consumer peer support, and education and training to consumers on their duties under the program. However, the regulation (18 NYCRR 505.28) does not mention these delegated services. How does the Department plan to address this discrepancy, and which set of guidelines should bidders follow?	Bidders should refer to sections 4.1 and 4.2 of the RFP. Bidders are directed to defer to the statutory amendment of Social Services Law 365-f as enacted by L.2024, c. 57, pt. HH, §§ 1 to 7. Bidders are directed to advice from their legal advisors regarding matters of standard legal interpretation.
900	Scope of Work	Section 4.1: Required Fiscal Intermediary Services, Bullet j) (Page 5 of RFP)	What additional services, if any, has the Commissioner of Health specified regarding the responsibilities of FIs?	Current FI services are listed in Section 4 of the RFP.
901	Scope of Work	Section 4.1: Required Fiscal Intermediary Services, Bullet j) (Page 5 of RFP)	Does the Commissioner of Health have any plans to specify further or change the responsibilities of FIs?	Current FI services are listed in Section 4 of the RFP.

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902	Scope of Work	Section 4.1: Required Fiscal Intermediary Services, Bullet j) (Page 5 of RFP)	What additional services will be required?	Current FI services are listed in Section 4 of the RFP.
903	Scope of Work	Section 4.1: Required Fiscal Intermediary Services, Bullet j) (Page 5 of RFP)	With regard to this requirement, "Any additional services required to be performed pursuant to regulations established by the Commissioner of Health specifying the responsibilities of FIs providing services under this title.," is the state anticipating specific additional services at this time?	No.
904	Scope of Work		Sections 4.1-4.5 include customer service-type requirements for the Statewide FI. The Statewide FI must be able to provide stellar customer service to numerous and diverse stakeholders including consumers, designated representatives, informal caregivers, and personal assistants. CDPAP consumers are low income as they are eligible for Medicaid and have disabilities as they need home and community-based services. Customer service must therefore be accessible linguistically and provided in multiple modalities to meet the customer need. Many CDPAP consumers have personal relationship with the staff at their FIs and contact them over the phone, text and email. These modes of communication, especially phone communication with a live person, should be preserved in the contract. An online and/or Mobile Application system may be sufficient for some consumer participants, but other participants lack access to a smartphone, don't have access to the internet, or do not know how to use computer or smartphone technology. •Must the Statewide FI provide customer service over the phone by a live person? If yes, this should be clarified in the contract. •Assuming that the customer service phone line is required: oWhat are the quality requirements for the Statewide FI customer service line regarding wait times, call abandonment rates, and accuracy of the information provided? What are the monetary penalties for the Statewide FI's failure to meet these requirements? •What provisions must the Statewide FI make to ensure they can speak with health care proxies, powers of attorney, informal caregivers without undue delay regarding the CDPAP consumer's case? •Consumers, families, and PAs in New York speak many languages. What provisions are required by the Statewide FI to serve LEP individuals in their preferred language? What are the monetary penalties for failure to do so? •Some consumers, families, and PAs are Deaf, Hard of Hearing, unable to speak, or are blind. What provisions are required by the Statewide FI to serve such individuals? What are the contractual monetary penalties for failure to provide these services?	The Statewide Fiscal Intermediary, by itself or through subcontractors, must have the means by which to engage with consumers and personal assistants to onboard each consumer and personal assistant, provide information, guidance and assistance, and otherwise carry out its responsibilities under the contract. In the proposal, bidders should outline the means by which these responsibilities to engage with consumers and personal assistants will be met.
905	Scope of Work	Section 4.0: Scope of Work (Page 5 of RFP)	Can the Department clarify that by "facilitate the delivery of fiscal intermediary services," all Required Fiscal Intermediary Services listed in Section 4.1 are included?	The bidder will be responsible for all scope of work as outlined in RFP Section 4.
906	Scope of Work	Section 4.1: Required Fiscal Intermediary Services, Paragraph 1 (Page 5 of RFP)	Can we get clarity as to whether the list of "fiscal intermediary responsibilities" is for the Single FI or the subcontractor?	See RFP Section 5.7 for responsibilities a subcontractor cannot perform.
907	SPA	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	If an applicant provides statewide Fiscal Intermediary services in State that does not provide the Community First Choice Option, should the applicant review the current NYS CFCO State plan to ensure compliance, or will there be an amendment to the NYS CFCO State Plan before the Statewide FI is implemented?	The applicant will be expected to comply with existing NYS CFCO requirements.
908	SPA	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	According to 42 CFR § 441.530 Home and Community-Based Setting, the setting must facilitate individual choice regarding services and supports, and who provides them. Will the statewide Fiscal Intermediary (FI) be considered a home and community-based setting under this regulation, as per the compliance requirements outlined in Section 4.4 of the RFP?	This question is unclear and will not be answered.

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909	Subcontracting - Add'l Reqs	Section 5.7: Subcontracting (Pages 15-16 of RFP)	The RFP states that the State may impose additional subcontracting requirements or restrictions after the award of the contract. Such additional requirements or restrictions may materially impact the nature of the bid (cost, operational structure, or both). Can the State provide more detail about the restrictions or requirements it might consider to ensure that the bids are as accurate and reliable as possible?	No additional requirements have been determined at this time.
910	Subcontracting - Add'l Reqs	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Can the Department provide examples or more details on the specific additional requirements and restrictions they may introduce on subcontracting so entities can proactively prepare accordingly?	No additional requirements have been determined at this time.
911	Subcontracting - Add'l Reqs	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Aside from the RFP requirements for subcontractors will DOH establish additional qualifications?	No additional requirements have been determined at this time.
912	Subcontracting - Add'l Reqs	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Besides the requirements for subcontractor agreements set forth in this section, what "additional requirements and restrictions on subcontracting" might the Department introduce "after the award, through the contract with the Department"? For transparency, why did the Department not include all requirements in the RFP?	No additional requirements have been determined at this time.
913	Subcontracting - Changes	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Are there any restrictions to adding subcontractors that are not identified in the RFP submission?	Per RFP Section 5.7, the Department reserves the right to review and approve all subcontractor agreements including any additions, changes to or removal of subcontractors. The Statewide Fiscal Intermediary is responsible for their subcontracts and would be required to notify the Department of changes to their agreements, which could be subject to the Department's approval.
914	Subcontracting - Changes	Section 2.1: Background Information (Page 3 of RFP)	Will centers for independent living have to notify the Department of Health if the terms of their contracts change or if their contract ends?	See answer to Question #913
915	Subcontracting - Changes	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Please confirm that a change of the equity owners of a current FI that has been providing FI services since prior to 2012 will not impact the FI's ability to be considered as a subcontractor for the statewide FI	See answer to Question #913
916	Subcontracting - Changes	Section 5.7: Subcontracting (Pages 15-16 of RFP)	What, if any, restrictions will apply to a subcontractor's ability to assign its subcontract with the awarded Statewide Fiscal Intermediary, whether required to be included as a term in the subcontract agreement or otherwise?	See answer to Question #913
917	Subcontracting - Compliance	Section 4.0: Scope of Work (Page 5 of RFP)	The RFP states that the Statewide Fiscal Intermediary is responsible for making sure that subcontractors "meet all applicable federal and state laws and regulations." What federal and state laws and regulations apply to subcontractors of fiscal intermediary services?	This will be determined by the services being provided by the subcontractors and monitored by the contracted Statewide Fiscal Intermediary.
918	Subcontracting - Compliance	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	What are the responsibilities of the SFI for violations of law or fraud by one of its subcontractors? Will the subcontractors be subject to separate enforcement actions by the relevant state agency?	The contracted Statewide Fiscal Intermediary is responsible for oversight of its subcontractors.
919	Subcontracting - Compliance	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Paragraph 1 (Pages 7 8 of RFP)	Given that the statute requires any managed care plans, managed long-term care plans, local social service districts, and other appropriate long-term service programs offering CDPAS to contract with the Statewide FI, can the Department clarify the specific responsibilities and accountability measures in place for the SFI concerning violations of law or fraud by subcontractors, either directly or indirectly for FI services? Will subcontractors be subject to separate enforcement actions by DOH, OMIG, OAG, and others independently of the SFI?	See answer to Question #918
920	Subcontracting - Compliance	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	The statute does not specify who bears the risk for corporate compliance matters such as fraud between the Statewide Fiscal Intermediary and its subcontractors. Can the Department clarify the legal and operational responsibilities and liabilities for both parties to prevent potential legal disputes and ensure accountability?	See answer to Question #918

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921	Subcontracting - Compliance	Section 5.7: Subcontracting (Pages 15-16 of RFP)	RFP Section 5.7 Paragraph 5 & 6: "Subcontractors may provide services and support functions that assist or enable the Awarded Statewide FI to perform FI services. Subcontractors may NOT directly perform any of the following: • enter into a contract for the provision of fiscal intermediary services with the Department; • set wages and establishing benefits for personal assistants (PAs); • maintain workers compensation, disability, or unemployment insurance policies for PAs; • appear at workers compensation, disability or unemployment hearings; • maintain personnel records for each PA and maintain records of Consumers' service authorization or plan of care (subcontractors may maintain copies or duplicate records); • enter into Department approved memoranda of understanding with Consumers; or • enter into contract with managed care organizations. In any arrangement between the Statewide FI and a subcontractor, the Statewide FI shall retain and acknowledge responsibility as joint employer of the PA, to the extent of such employment responsibilities, as if contractor had not engaged a subcontractor for the performance of any duties, best practices, or other services related to this RFP and FI services."Please provide examples of work a subcontractor can do. If the Statewide FI has concerns over a subcontractor's performance of duties, what recourse can the Statewide FI take?	See answer to Question #918 and Question #996
922	Subcontracting - Compliance	Section 5.7: Subcontracting (Pages 15-16 of RFP)	RFP Section 5.7 Paragraph 7: "In addition, the Statewide FI shall: • Require subcontractors to promptly notify Statewide FI of any court case, administrative hearing, or other proceeding in which the subcontractor is named with respect to any PA's labor or employment-related claim (including, but not limited to, claims for lost wages, unemployment insurance, workers compensation, etc.); and • Agree to intervene in any such proceeding and to indemnify and hold harmless subcontractors with regard to any liability incurred as a result of a decision, verdict, or other determination rendered with respect to such claims." What oversight, authority does the Statewide FI have over its subcontractors if they are to hold harmless the subcontractor if the subcontractor does not follow NYS Regulations, Federal Laws, or policies of the Statewide FI? What would be the Statewide FI's recourse should a subcontractor fail to comply with State and Federal laws?	See the New York State Department of Health Contract Section VIII.C and VIII.F, and Section IX.J.
923	Subcontracting - Compliance	Section 5.7: Subcontracting (Pages 15-16 of RFP)	How will the Statewide FI manage and oversee subcontractor performance?	See answer to Question #918
924	Subcontracting - Eligibility	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Will all current FI be made subcontractors if they have CDPAP members?	No. Only those entities chosen by the awarded bidder and contracted with by such awarded bidder will be subcontractors.
925	Subcontracting - Eligibility	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Is the State expecting the single statewide FI to subcontract to existing FIs, to CDPAP enrolled Medicaid providers, or to both?	Refer to RFP Section 4.0 for subcontractor requirements
926	Subcontracting - Eligibility	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Can the single statewide FI subcontract directly to CDPAP enrolled Medicaid providers, in addition to existing FIs?	Refer to RFP Section 4.0 for subcontractor requirements
927	Subcontracting - Eligibility	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Is the State expecting LHCSAs to become subcontractors to the single statewide FI as well?	Refer to RFP Section 4.0 for subcontractor requirements
928	Subcontracting - Eligibility	General	Would the Department select a vendor that has not been continuously providing services since 1/1/12, which is a provision of the law, but not the RFP, if all the RFP requirements are met?	The provision of law is that subcontractors must meet this date requirement, not the bidding vendor.
929	Subcontracting - Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Is a FI that has not been operating since before 1/1/2012 still eligible?	Only if they are a independent living center licensed under Education Law Section 1121 and have been providing fiscal intermediary services since January 1, 2024.

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930	Subcontracting - Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	If a bidder is deemed ineligible for award as the Statewide FI due to insufficient ability to meet the minimum requirements specified within this RFP (e.g., providing services on a statewide basis in at least on other state), will their failure to meet these requirements in any way exclude or impede the entity's ability to assume a subcontractor role (assuming they meet all applicable subcontractor eligibility criteria)? Are there other ramifications the Department can provide for entities submitting a Statewide FI bid/application but failing to meet the minimum qualifications, aside from Department not awarded that entity the Statewide FI contract?	Failure to meet the eligibility requirements as a bidder would not preclude an organization from being a subcontractor provided the organization meets the subcontracting requirements.
931	Subcontracting - Eligibility	Section 4.0: Scope of Work (Page 5 of RFP)	Under New York law, the Fiscal Intermediary may be a "service center for independent living." However, Section 4.0 of the RFP states that the FI must subcontract to service centers for independent living. Therefore, the RFP appears to be more constricting than the statutory language, thereby precluding service centers for independent living from becoming the FI. How does the Department justify such language in Section 4.0 of the RFP?	SSL 365-f was amended by L.2024, c. 57, pt. HH, §§ 1 to 7, eff. April 20, 2024, deemed eff. April 1, 2024. SSL 365-f states that the "eligible contractor is capable of performing statewide fiscal intermediary services with demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce, has experience serving individuals with disabilities, and as of April first, two thousand twenty-four is providing services as a fiscal intermediary on a statewide basis with at least one other state;"
932	Subcontracting - Eligibility	Section 4.0: Scope of Work (Page 5 of RFP)	What criteria define whether a NYS DOH MLTC rate setting region subcontractor "has been providing fiscal intermediary services since January 1, 2012, or earlier"?	The organization must have been acting in the capacity of an FI, including contracting with managed care plans/LDSS and/or have been billing Medicaid for CDPAP services.
933	Subcontracting - Eligibility	Section 5.7: Subcontracting (Pages 15-16 of RFP)	What specific qualifications are required for subcontractors to be approved by the Department of Health, as outlined in Section 5.7 of the RFP?	Per SSL 365-f, subcontractors are required to register with the Department. The specifics of the registration process have not yet been determined.
934	Subcontracting - Eligibility	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Please confirm that an entity that satisfies the requirements to be a subcontractor can be engaged by the single FI even if there is a change of ownership of the subcontractor that is pending and has not been completed as of the date of the NYS contract with the single FI.	See answer to Question #933
935	Subcontracting - Eligibility	Section 4.0: Scope of Work, Third Bullet (Page 5 of RFP	If the statewide FI choses to subcontract with more than one entity in a particular rate region, do all subcontractors need to have a proven record of delivering fiscal intermediary services since January 1, 2012, or only one?	All subcontractors must meet the eligibility requirements.
936	Subcontracting - General	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet c) (Page 8 of RFP)	How does the requirement to "[m]aintain an organizational chart with professional and managerial lines of authority" apply to subcontractors?	This relates to the Statewide Fiscal Intermediary.
937	Subcontracting - General	Section 2.2: Other Important NYS Contracting Information for Bidders (Pages 3-4 of RFP)	Do subcontractors have to sign Attachment 8?	No, the awarded contractor is the only entity who is required to sign Attachment 8. Please note, this attachment is not required to be submitted by any bidder.
938	Subcontracting - General	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Is there any requirement to submit an RFP to be considered as a subcontractor when the single FI is awarded?	No. All planned subcontracting arrangements would be negotiated with the resulting contracted statewide fiscal intermediary. Subcontractor registration, as outlined in SSL 365-f, will occur after a contract has been approved by the Department with the awarded statewide fiscal intermediary.
939	Subcontracting - General	Section 2.1: Background Information (Page 3 of RFP)	Will subcontracts also be 5-year terms?	Subcontracts do not require a five year term.
940	Subcontracting - General	Section 4.0: Scope of Work (Page 5 of RFP)	Can an entity that has been awarded a subcontract under 4.0 enter a further subcontract with an agency that has not been providing fiscal intermediary services since January 1, 2012?	No.
941	Subcontracting - General	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet b) (Page 8 of RFP)	How does the requirement to "[h]ave and maintain an effective organizational structure with qualified administrative staff" apply to subcontractors?	This relates to the Statewide Fiscal Intermediary.
942	Subcontracting - General	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	Will each subcontractor have to submit concerns to the Statewide FI?	This question is unclear and cannot be answered.

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943	Subcontracting - General	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	Section 5.5 states that "subcontractors awarded a subcontract over $25,000 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements" must undertake programs to ensure that minorities and women are afforded equal employment without discrimination, "except where the Work is for the beneficial use of the awarded Statewide FI." How will the DOH define "beneficial use" in this context?	This question is not relevant to the development of a proposal under this RFP.
944	Subcontracting - General	Attachment D: Region/County Mapping for MLTC Rate Setting Regions (Page 32 of RFP)	Why was a non-contiguous regional delineation made and how does it benefit consumers or	These are the existing MLTC rate setting regions.
945	Subcontracting - ILC	Section 4.0: Scope of Work (Page 5 of RFP)	Section 4 of the RFP requires the Statewide FI to subcontract with service centers for independent living. However, Part HH of Chapter 57 of the Laws of 2024 states a different requirement. Can you clarify this discrepancy?	SSL 365-f outlines the requirements an entity must meet to be considered an eligible subcontractor under the ILC provision. The Contractor will be expected to offer to subcontract with all independent living centers that meet the criteria identified in Section 4.0 of the RFP. However, independent living centers may choose not to participate under the resulting contract as a subcontractor. In this situation, the Contractor would not be considered non-compliant. Regardless, the awarded Contractor will be strongly encouraged to make any and all good-faith efforts required to secure a subcontract with independent living centers.
946	Subcontracting - ILC	Section 4.0: Scope of Work (Page 5 of RFP)	If a service center for independent living refuses to subcontract with the Statewide FI or an agreement cannot be reached, what resources does the Statewide FI have? Will they be considered non-compliant with the statute?	See answer to Question #945
947	Subcontracting - ILC	Section 4.0: Scope of Work (Page 5 of RFP)	What if a service center for independent living chooses not to be a subcontractor? What is the Department's vision of how that will work?	See answer to Question #945
948	Subcontracting - ILC	Section 4.0: Scope of Work (Page 5 of RFP)	The language in the RFP concerning subcontracting with service centers for independent living appears to deviate from the statutory language. The RFP specifies "each entity," implying that all independent living centers meeting the criteria are eligible for subcontracting with the awarded SFI, whereas the law states "an entity," suggesting only a single independent living center is required. The RFP states, "Subcontracting to facilitate the delivery of fiscal intermediary services to each entity that is a service center for independent living under section 1121 of the New York State Education Law ("EDN") and has been providing fiscal intermediary services since January 1, 2024…", while the statute explicitly states, "The statewide fiscal intermediary shall subcontract to facilitate the delivery of fiscal intermediary services to an entity that is a service center for independent living under section one thousand one hundred twenty-one of the education law that has been providing fiscal intermediary services since January first, two thousand twenty-four or earlier." Can the Department clarify this discrepancy?	See answer to Question #945
949	Subcontracting - ILC	Section 4.0: Scope of Work (Page 5 of RFP)	Can the discrepancy between the statutory language ("an entity") and the RFP ("each entity") with regards to contracting with independent living centers be clarified?	See answer to Question #945
950	Subcontracting - ILC	Section 4.0: Scope of Work (Page 5 of RFP)	Given that the statute and RFP "require" the Single FI to contract with "every" Independent Living Centers, what happens if the Single FI and a ILC cannot comes to terms of a contract? Is the Single FI considered in breach of the RFP?	See answer to Question #945
951	Subcontracting - ILC	Section 4.0: Scope of Work (Page 5 of RFP)	Can the Department please clarify that the Statewide Fiscal Intermediary will be subcontracting to "facilitate the delivery of fiscal intermediary services" by, and not to, each entity that is a service center for independent living under section 1121 of the NYS Education Law and has been providing fiscal intermediary service since January 1, 2024, or earlier?	See answer to Question #945
952	Subcontracting - ILC	Section 4.0: Scope of Work (Page 5 of RFP)	The RFP states that the successful FI is required to subcontract with "each" independent living center. The legislation authorizing the single FI states a requirement to contract with "an" independent living center. Please confirm the ILC subcontracting requirement.	See answer to Question #945
953	Subcontracting - ILC	Section 5.7: Subcontracting (Pages 15-16 of RFP)	What happens if the mandatory subcontracts with Centers for Independent Living cannot be successfully negotiated?	See answer to Question #945

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954	Subcontracting - ILC	Section 4.0: Scope of Work (Page 5 of RFP)	May an FI that began providing fiscal intermediary services after January 1, 2012 be a subcontractor?	Only if the FI is an independent living center under section 1121 of the New York State Education Law and has been providing FI services since January 1, 2024 or earlier.
955	Subcontracting - ILC	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Which ILCs are required subcontractors? In which MLTC Rate Setting Regions are they located?	The Department does not have this information.
956	Subcontracting - Lists	Section 4.0: Scope of Work (Page 5 of RFP)	Does the Department of Health have a list of each entity that is a service center for independent living under section 1121 of the New York State Education Law and has been providing fiscal intermediary services since January 1, 2024, and, if so, will the Department provide that list?	A listing of all independent living centers can be found at: https://www.acces.nysed.gov/vr/independent-living-centers . The Department does not have a listing of which of those have been providing fiscal intermediary services.
957	Subcontracting - Lists	Section 4.0: Scope of Work (Page 5 of RFP)	Does the Department of Health have a list of each entity per NYS DOH MLTC rate setting region, that has a proven record of delivering services to individuals with disabilities and the senior population and has been providing fiscal intermediary services since January 1, 2012, or earlier and, if so, will the Department provide that list?	No, the Department does not have this information.
958	Subcontracting - Lists	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Will the State help the new statewide FI identify existing FIs and CDPAP enrolled Medicaid providers to make contact to consider a subcontracting relationship?	No.
959	Subcontracting - Lists	Section 4.0: Scope of Work, Third Bullet (Page 5 of RFP)	Will DOH publish or otherwise make available, prior to the deadline for submission of proposals, a list of fiscal intermediaries that have been providing fiscal intermediary services since January 1, 2012, and their service areas, so RFP respondents can identify potential subcontractors?	No.
960	Subcontracting - Lists	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	Will a list of eligible subcontractors be provided? Or is it up to the Single FI to determine eligibility of each separate subcontractor?	The Statewide Fiscal Intermediary will be responsible for vetting any subcontractors and they are subject to approval by the Department.
961	Subcontracting - Lists	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet a) (Page 8 of RFP)	Will the Department of Health provide a list of eligible subcontractor entities?	No.
962	Subcontracting - Number	General	How many subcontractors is the State expecting the single statewide FI to hire?	The bidder must meet the minimum number subcontractors as outlined in the RFP. Otherwise, the number of subcontractors is at the discretion of the bidder provided each subcontractor meets the RFP requirements.
963	Subcontracting - Number	Section 4.0: Scope of Work (Page 5 of RFP)	What is the minimum number of independent living centers that the contractor must subcontract with?	See answer to Question #962
964	Subcontracting - Number	General	Is the State expecting the single statewide FI to work with existing FIs in every NYS County?	See answer to Question #962
965	Subcontracting - Number	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Are there limits on the number of subcontractors after the minimum subcontracting requirements are met?	See answer to Question #962
966	Subcontracting - Number	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Are there limits on the type of subcontractors after the minimum subcontracting requirements are met?	See answer to Question #962
967	Subcontracting - Number	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	According to Section 4.5 of the RFP, the awarded Statewide Fiscal Intermediary (FI) will work with subcontractors and entities throughout the state. Is there a limit to the number of subcontractors that can be included in the bid?	See answer to Question #962
968	Subcontracting - Number	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Is there any limit on the number of FI subcontractors that the Statewide FI may contract with? If so, what are the limits?	See answer to Question #962
969	Subcontracting - Number	Section 5.7: Subcontracting (Pages 15-16 of RFP)	The RFP states "Bidders may propose the use of subcontractors consistent with this section. The Department reserves the right to review to review and approve all subcontractor agreements." How many subcontractors can the bidder propose? Must the bidder propose to use at least one subcontractor that is a service center for independent living and at least one subcontractor in each NYS DOH MLTC rate setting region?	See answer to Question #962
970	Subcontracting - Number	Section 4.0: Scope of Work (Page 5 of RFP)	Are there any limitations on the number and type of subcontractors, or the work that they can perform? If they are not an approved Medicaid provider, will the State approve their application in a timely manner?	See answer to Question #962

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971	Subcontracting - Proposal	Section 3.0: Bidders Qualifications (Page 4 of RFP)	According to 42 CFR § 441.530 Home and Community-Based Setting, the setting must facilitate individual choice regarding services and supports, and who provides them. To facilitate choice, can additional subcontractors be included in the bid?	See answer to Question #962
972	Subcontracting - Number	Section 4.0: Scope of Work, Paragraph 1 (Page 5 of RFP)	Can the Department clarify whether the awarded SFI is required to subcontract with one (1) distinct entity per MLTC rate-setting region, totaling four (4) entities, or if the Department permits the awarded SFI to subcontract with a single entity to serve all four (4) MLTC rate-setting regions, totaling one (1) entity, provided that the entity meets the criteria of having a proven record of delivering services to individuals with disabilities and the senior population since January 1, 2012, as detailed in Attachment D?	At least one entity per rate setting region or at least four entities statewide.
973	Subcontracting - Number	Section 4.0: Scope of Work (Page 5 of RFP)	What is the minimum number of entities per NYS DOH MLTC rate setting region that the contractor must subcontract with?	At least one entity per rate setting region or at least four entities statewide.
974	Subcontracting - Number	Section 5.7: Subcontracting (Pages 15-16 of RFP)	If the SFI has to subcontract with the at least one ILS and one Managed Care Entity per region, how many FI's are eligible to receive the contract?	Only one contract will be awarded through the RFP. The awarded contractor may choose to subcontract with multiple entities consistent with the requirements for subcontracting outlined in the RFP.
975	Subcontracting - Number	Section 4.0: Scope of Work (Page 5 of RFP)	What does the requirement "subcontracting with at least one entity per NYS DOH MLTC rate setting region, as seen in Attachment D" mean?	The Statewide Fiscal Intermediary must subcontract with at least one entity in each of the regions outlined in Attachment D that meets the subcontracting requirements.
976	Subcontracting - Number	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Will DOH require or allow the Statewide FI to provide consumers a choice of Subcontractors through which to facilitate FI services?	Subcontractors must meet any requirements as outlined in the RFP regarding the type or number of subcontractors. Otherwise, bidders have discretion in the subcontractors they choose to work with, subject to approval by the Department.
977	Subcontracting - Overseas	Section 4.8: Information Technology Requirements (Page 10 of RFP)	Given the heightened vulnerability of the healthcare sector to cybersecurity risks and the significant increase in cyber incidents, particularly ransomware attacks, tracked by the U.S. Department of Health and Human Services (HHS), will the Department of Health (DOH) allow the use of overseas call centers, consultants, or subcontractors to support the awarded Statewide Fiscal Intermediary (FI)?	All Data shall remain in the Continental United States {CONUS). Any Data stored, or acted upon, must be located solely in Data Centers in CONUS. Services which directly or indirectly access Data may only be performed from locations within CONUS.
978	Subcontracting - Overseas	Section 4.8: Information Technology Requirements (Page 10 of RFP)	Will the DOH review and approve the use of out-of-state administrative work to ensure compliance with cybersecurity standards and protect sensitive data? Per the NYS-P03-002 Information Security Policy, Section 4.4, Information Risk Management, risk assessments must include additional considerations when systems, services, or information will reside, or be accessed from, outside of the Contiguous United States (CONUS) to ensure compliance with relevant statutory, regulatory, and contractual requirements. Risk assessment results, and the decisions made based on these results, must be documented.	All Data shall remain in the Continental United States {CONUS). Any Data stored, or acted upon, must be located solely in Data Centers in CONUS. Services which directly or indirectly access Data may only be performed from locations within CONUS.
979	Subcontracting - Overseas	Section 4.8: Information Technology Requirements (Page 10 of RFP)	If the qualified bidder has provided statewide FI services in another state using overseas call centers or administrative services contracted to overseas entities, should this be disclosed in the response to the RFP? Additionally, what specific documentation or information should be included to ensure full transparency and compliance with NYSDOH requirements?	All Data shall remain in the Continental United States {CONUS). Any Data stored, or acted upon, must be located solely in Data Centers in CONUS. Services which directly or indirectly access Data may only be performed from locations within CONUS.
980	Subcontracting - Overseas	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Is there any requirement that all subcontractor work must be performed in New York State, as outlined in Section 5.7 of the RFP?	All Data shall remain in the Continental United States {CONUS). Any Data stored, or acted upon, must be located solely in Data Centers in CONUS. Services which directly or indirectly access Data may only be performed from locations within CONUS.
981	Subcontracting - Overseas	Section 5.7: Subcontracting (Pages 15-16 of RFP)	If not any requirement that all subcontractor work must be performed in New York State, is there a percentage of work that must be performed in-state, as outlined in Section 5.7 of the RFP?	All Data shall remain in the Continental United States {CONUS). Any Data stored, or acted upon, must be located solely in Data Centers in CONUS. Services which directly or indirectly access Data may only be performed from locations within CONUS.
982	Subcontracting - Payment	Section 4.0: Scope of Work (Page 5 of RFP)	Are there any requirements regarding the rate to be paid to the independent living center subcontractor(s)?	Subcontracts and the amount to be paid to each subcontractor will be determined by negotiations between the contracted statewide fiscal intermediary and their approved subcontractors. The Department will not determine subcontract rates of payment.

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983	Subcontracting - Payment	Section 4.0: Scope of Work (Page 5 of RFP)	Are there any requirements regarding the rate to be paid to the NYS DOH MLTC rate setting region subcontractor(s)?	This will be negotiated between the Statewide FI and the subcontractor based upon services the Statewide FI chooses to delegate.
984	Subcontracting - Payment	Section 4.0: Scope of Work (Page 5 of RFP)	Are there any requirements regarding the rate to be paid to the NYS DOH MLTC rate setting region subcontractor(s)?	No. Subcontracting payment terms will be negotiated between the Statewide FI and the subcontractor.
985	Subcontracting - Payment	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Is there any requirement for the single statewide FI to pay the subcontractors at their current Medicaid rates?	No.
986	Subcontracting - Payment	Section 4.0: Scope of Work (Page 5 of RFP)	Under Section 4.0, FISCAL INTERMEDIARY SCOPE OF WORK, does the bulleted phrase "Subcontracting to facilitate the delivery of fiscal intermediary services to each entity that is a service center for independent living under section 1121 of the New York State Education Law ("EDN")…" mean that service centers for independent living meeting this criteria will be able to continue to directly perform all of the fiscal intermediary (FI) services described in SSL § 365-f (4-a)(a)(ii), 18 NYCRR § 505.28(i) and 10 NYCRR § 766.11(c)-(d)?	Subcontractors will not be able to directly bill New York State for fiscal intermediary services nor will they be able to contract with managed care organizations or Local Departments of Social Services.
987	Subcontracting - Payment	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Is the FI contractor required to make vendor payments, i.e., supplies and equipment?	The contracted statewide fiscal intermediary is required to make payments to fulfill their contractual and sub contractual obligations.
988	Subcontracting - Payment	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	Will subcontractors be required to submit cost reports to the state?	No.
989	Subcontracting - Payment	Section 5.4: Payment (Page 12 of RFP)	Will DOH oversee the payment structure between the single FI and subsidiaries? Will DOH require that subsidiaries are paid a sum sufficient to cover their direct and administrative costs?	No. Payment for subcontracting is the responsibility of the Statewide Fiscal Intermediary.
990	Subcontracting - Payment	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Do Subcontractors need to enroll in the Medicaid Program?	No.
991	Subcontracting - Payment	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Will these records have to be submitted to the Statewide FI for billing, or will subcontractors bill for direct care services and process payroll for PAs?	Payments for subcontracting costs will be paid directly from the Statewide Fiscal Intermediary per the terms of the subcontract agreed upon between the two parties.
992	Subcontracting - Payment	Section 5.7: Subcontracting (Pages 15-16 of RFP)	How will subcontractors be compensated for costs associated with training and onboarding consumers?	Payments for subcontracting costs will be paid directly from the Statewide Fiscal Intermediary per the terms of the subcontract agreed upon between the two parties.
993	Subcontracting - Payment	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet b) (Page 9 of RFP)	Will subcontractors use the same written fiscal procedures?	No, as the subcontractors will not be billing Medicaid.
994	Subcontracting - Proposal	Section 2.0: Overview and Important Information (Page 3 of RFP)	Will the single contract awarded under this RFP include identification of subcontractors as part of the award?	The proposal should provide sufficient information to demonstrate how the Statewide Fiscal Intermediary will fulfill the responsibilities outlined in the RFP including its plans for the RFP required subcontracting. Specific identification of the subcontractors or commitment of those subcontractors is not required at the time of proposal submission.
995	Subcontracting - Proposal	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Please confirm that an applicant is not required to include any information about its subcontractors in the RFP submission.	See answer to Question #994
996	Subcontracting - Proposal	Section 5.7: Subcontracting (Pages 15-16 of RFP)	How should the specific qualifications, which are required for subcontractors to be approved by the Department of Health, be documented in the bid submission?	See answer to Question #994
997	Subcontracting - Proposal	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Should the RFP include possible subcontractors if they were to be approved for SFI?	See answer to Question #994
998	Subcontracting - Proposal	General	What requirements are there for the bidder to specify the use of subcontractors (for any and all purposes such as language/cultural competence of staff and call center staff, EVV solutions, data analytics and other purposes) at a regional level?	See answer to Question #994
999	Subcontracting - Proposal	Section 2.1: Background Information (Page 3 of RFP)	Does the proposal from a prospective single statewide fiscal intermediary need to identify which regional subcontractors the single statewide fiscal intermediary will use? Is this different for independent living center subcontractors?	See answer to Question #994
1000	Subcontracting - Proposal	Section 2.1: Background Information (Page 3 of RFP)	What form of commitment must the prospective single statewide fiscal intermediary obtain from subcontractors as part of the bidding process? Is this different for independent living center subcontractors?	See answer to Question #994

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1001	Subcontracting - Proposal	Section 2.1: Background Information (Page 3 of RFP)	Does this commitment need to be submitted as part of the application? Is this different for independent living center subcontractors? What happens if the subcontractors change?	See answer to Question #994
1002	Subcontracting - Proposal	Section 2.1: Background Information (Page 3 of RFP)	Is the identification of subcontractors in the application a material term for the contract? Is this different for independent living center subcontractors?	See answer to Question #994
1003	Subcontracting - Proposal	Section 2.1: Background Information (Page 3 of RFP) and Section 4.0: Scope of Work, Third Bullet (Page 5 of RFP)	We assume the subcontractor cited in this section are the same as the subcontractor requirement defined in RFP Proposal section 4.0, Bullet 3. Please confirm. If not, please elaborate on the requirement.	See answer to Question #994
1004	Subcontracting - Proposal	Section 2.1: Background Information (Page 3 of RFP)	How will the Statewide FI disclose/submit the subcontractors it will use to DOH?	See answer to Question #994
1005	Subcontracting - Proposal	Section 4.0: Scope of Work (Page 5 of RFP)	Will the selected FI be required to contract with the subcontractors it identifies in its offer?	See answer to Question #994
1006	Subcontracting - Proposal	Section 4.0: Scope of Work (Page 5 of RFP)	Will the Department make determinations regarding the competencies of subcontractors as a part of the RFP review process?	See answer to Question #994
1007	Subcontracting - Proposal	Section 4.0: Scope of Work (Page 5 of RFP)	Will the Department make determinations regarding the eligibility of subcontractors as part of the RFP review process?	See answer to Question #994
1008	Subcontracting - Proposal	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Do Statewide FI bidders have to submit proposals for subcontracts with Centers for Independent Living and with eligible entities in each rate setting region as part of their bid? Is there a timeframe for the subcontracts with these entities to begin before the Statewide FI is in breach of contract with the DOH?	See answer to Question #994
1009	Subcontracting - Proposal	Attachment B: Bidder's Demonstration of Eligibility to Submit an Offer (Pages 29-30 of RFP)	Why does it include the statement "(check all that apply)" if 365-f requires the statewide FI to contract with centers for independent living and at least one other subcontractor for each rate setting region.	Attachment B is used to assist the Department in determining eligibility of the bidder and the proposal for evaluation.
1010	Subcontracting - Reporting	Section 5.7: Subcontracting (Pages 15-16 of RFP)	How will the DOH determine the level of performance of subcontractors?	The statewide fiscal intermediary may be required to report on the performance of subcontractors. Specific reporting requirements of the Statewide Fiscal Intermediary and its subcontractors will be determined at the time of contract execution.
1011	Subcontracting - Reporting	Section 2.1: Background Information (Page 3 of RFP)	What specific metrics will subcontractors have to report? Do the subcontractors have to report to the single FI or DOH? How will compliance be monitored?	See answer to Question #1010
1012	Subcontracting - Roles	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Will Centers for Independent Living be allowed to verify that the health status of each PA is assessed prior to service delivery? This is not a prohibited task in section 5.7.	Bidders will determine what services they subcontract outside of those services that can only be performed by the contractor.
1013	Subcontracting - Roles	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Can subcontractors serve as the employer of record for personal assistants?	No. Only the statewide fiscal intermediary will be an employer of record for the personal assistant.
1014	Subcontracting - Roles	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Will service centers for independent living be permitted to enter into Department approved memoranda of understanding with Consumers?	No. Only the statewide fiscal intermediary will enter into memoranda of understanding with consumers.
1015	Subcontracting - Roles	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Will Centers for Independent Living be allowed to process income tax and other required wage withholdings? This is not a prohibited task in section 5.7.	No. Only the statewide fiscal intermediary will process income tax and other required wage withholdings.
1016	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Can the subcontractor perform billing and payroll services on behalf of the Statewide FI?	Prohibited subcontractor responsibilities are outlined in Section 5.7 of the RFP.
1017	Subcontracting - Roles	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Are Independent Living Center's full FI's that can bill, process payroll, contract with MCO's, and obtain our own insurance benefits?	See answer to Question #1016

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1018	Subcontracting - Roles	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Required fiscal intermediary services include processing wages and benefits for each personal assistant (PA), including establishing the amount of each PA's wages. In Section 5.7, subcontractors are expressly forbidden to set wages and establish benefits for PAs, this section does not forbid other aspects of processing wages and benefits. Will Centers for Independent Living be allowed to process wages and benefits within the established parameters? If not, and the state is choosing to eliminate this option, which preserves some level of consumer choice, how does the state intend to ensure that problems with an SFI will not happen in New York?	See answer to Question #1016
1019	Subcontracting - Roles	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Will Centers for Independent Living be permitted to monitor the consumer's or designated representative's ability to fulfill their responsibilities, and will subcontractors be permitted to have direct contact with the authorizing entity to report concerns? This is not a prohibited task in Section 5.7.	See answer to Question #1016
1020	Subcontracting - Roles	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Will Centers for Independent Living be able to contact funders to obtain authorizations or reauthorizations for consumers? Section 5.7 prohibits subcontractors from maintaining records but allows them to maintain copies and duplicates.	See answer to Question #1016
1021	Subcontracting - Roles	Section 4.0: Scope of Work (Page 5 of RFP)	Besides the items a subcontractor cannot directly perform as listed in Section 5.7 of the RFP, are there any limitations on the extent to which the awarded Statewide Fiscal Intermediary can subcontract its responsibility for the delivery of fiscal intermediary services to consumers receiving CDPAS as defined in Part HH of Chapter 57 of the Laws of 2024? In other words, can the awarded Statewide Fiscal Intermediary subcontract all of its responsibilities other than those items listed in Section 5.7 of the RFP that a subcontractor cannot perform directly?	See answer to Question #1016
1022	Subcontracting - Roles	General	Could a subcontractor process payroll on behalf of the FI?	See answer to Question #1016
1023	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	The RFP states that "Subcontractors may provide services and support functions that assist or enable the Awarded Statewide FI to perform FI services." What are examples of services and supports that may be provided by the Subcontractors? Are there any prohibitions or limitations?	See answer to Question #1016
1024	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	The RFP states what a subcontractor cannot do. What are the roles and responsibilities of a subcontractor?	See answer to Question #1016
1025	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Can you provide a comprehensive list of activities subcontractors are prohibited from performing?	See answer to Question #1016
1026	Subcontracting - Roles	General	What is the Department's vision of the roles of any subcontractor used on this project, including service centers for independent living? In other words, what tasks would such subcontractors assume on behalf of the FI?	See answer to Question #1016
1027	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	May a subcontractor provide payroll services?	See answer to Question #1016
1028	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Are subcontractors permitted to process payroll and billing?	See answer to Question #1016
1029	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	May a subcontractor maintain PA records such as timesheets should it be deemed that a subcontractor can provide payroll services?	See answer to Question #1016
1030	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Can subcontractors perform other fundamental tasks/activities, such as those involving customer service and payroll processing?	See answer to Question #1016
1031	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	The RFP restricts services subcontractors can perform. Please validate what services listed in 4.1 (FI required services) a subcontractor can be delegated and which services cannot be delegated.	See answer to Question #1016
1032	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Section 5.7 paragraph 5 Will subcontractors be allowed to handle onboarding (hiring) tasks for PAs?	See answer to Question #1016
1033	Subcontracting - Roles	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Will Centers for Independent Living be allowed to verify that the health status of each PA is assessed prior to service delivery? This is not a prohibited task in section 5.7.	See answer to Question #1016

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1034	Subcontracting - Roles	Section 4.0: Scope of Work (Page 5 of RFP)	What specific subcontracting requirements will be required under the RFP?	See answer to Question #1016
1035	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Under Section 5.7, titled "Subcontracting," it states that subcontractors are not to "maintain personnel records for each PA and maintain records for consumer service authorization or plan of care." Are subcontractors permitted to onboard consumers and PAs by obtaining initial documentation?	See answer to Question #1016
1036	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	When can we expect to have more information on the requirement and allowable tasks of subcontractors?	See answer to Question #1016
1037	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	While identifying "Subcontracting to facilitate the delivery of fiscal intermediary services to each entity that is a service center for independent living under section 1121 of the New York State Education Law ("EDN") and has been providing fiscal intermediary services since January 1, 2024, or earlier" (Item 4.0, Page 5) in the section relating to subcontracting (Section 5.7, Page 15) The RFP forbids FI activities that were intended for IL Centers to continue to perform. What are the expectations for independent living centers to perform as an FI, if prohibited to perform backroom activities?	See answer to Question #1016
1038	Subcontracting - Roles	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Will all PAs be expected to be hired only through the Statewide FI, or will PAs be able to be hired through subcontractors?	While subcontractors may be able to assist the statewide fiscal intermediary with hiring of personal assistants, only the contracted statewide fiscal intermediary will be the employer of record for all personal assistants and the only entity who is able to bill for fiscal intermediary services through the State's Medicaid management information system (MMIS).
1039	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	22. Under Section 5.7 Subcontractors, a paragraph reads: "Subcontractors may provide services and support functions that assist or enable the Awarded Statewide FI to perform FI services. Subcontractors may NOT directly perform any of the following: • enter into a contract for the provision of fiscal intermediary services with the Department;• set wages and establishing benefits for personal assistants (PAs); • maintain workers compensation, disability, or unemployment insurance policies for PAs; • appear at workers compensation, disability or unemployment hearings; • maintain personnel records for each PA and maintain records of Consumers' service authorization or plan of care (subcontractors may maintain copies or duplicate records); •enter into Department approved memoranda of understanding with Consumers; or •enter into contract with managed care organizations". Does this apply to an entity that is a service center for independent living under section 1121 of the New York State Education Law ("EDN")?	Only the contracted statewide fiscal intermediary may perform the duties as outlined in the question.
1040	Subcontracting - Roles	Section 4.0: Scope of Work (Page 5 of RFP)	Can the Department provide clear guidelines on the subcontracting requirements that will be enforced under this RFP?	Refer to RFP Sections 4 and 5.7 for program requirements.
1041	Subcontracting - Roles	Section 4.0: Scope of Work, Paragraph 1 (Page 5 of RFP)	If an awarded Statewide Fiscal Intermediary (SFI) selects a subcontractor for one of the four MLTC regions to meet the State's subcontracting requirement, will that subcontracting entity be restricted to serving only within their specific region, or will the State permit the subcontractor to serve consumers across all regions if the SFI so chooses? This question seeks clarification on whether the SFI requirement to subcontract with at least one entity per NYS DOH MLTC rate-setting region imposes any geographical restrictions on the subcontractor's ability to perform delegated fiscal intermediary services beyond their designated region.	Subcontracting arrangements are at the discretion of the Statewide Fiscal Intermediary provided they meet the requirements as outlined in the RFP. Subcontractors are subject to the approval of the Department.
1042	Subcontracting - Roles	Section 4.0: Scope of Work (Page 5 of RFP)	Under Section 4.0, FISCAL INTERMEDIARY SCOPE OF WORK, does the bulleted phrase "Subcontracting to facilitate the delivery of fiscal intermediary services to each entity…" mean something different than the term "Subcontracting" used in the bullet that follows within the same section? If so, please explain the distinction.	These bullets outline the requirements potential subcontractors must meet to be an eligible subcontracting entity.

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1043	Subcontracting - Roles	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	Will the Statewide FI and/or its subcontractors be required to have a physical establishment within a certain region?	The Department has not defined timely delivery of services as it relates to maintaining a local presence in each of the outlined rate regions. The bidder should demonstrate in its Technical Proposal how they plan to maintain a local presence that allows for the timely delivery of services. How the bidder, through its own means or those of a subcontractor, meets this requirement is at the bidder's discretion and should be described in the Technical Proposal.
1044	Subcontracting - Roles	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet a) (Page 9 of RFP)	Are subcontractors required to complete cost reporting?	No.
1045	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Regarding the list of items that subcontractors may not perform under the scope of this engagement, the State indicates that FI subcontractors may not enter into FI-related contracts with managed care organizations. Please confirm that this restriction relates only to the FI scope of work contained within this RFP.	Entities may not enter into contracts with managed care plans for fiscal intermediary services.
1046	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Section 5.7 specifies that subcontractors may not appear at workers' compensation, disability or unemployment hearings. Would this restriction also apply to court cases, administrative hearings or other proceedings where the subcontractor is named explicitly?	No. This provision applies to "workers compensation, disability, or unemployment hearings."
1047	Subcontracting - Roles	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Will DOH allow the single FI to contractually transfer joint employer risk to subcontractors? Will DOH allow indemnification provisions in subcontracts related to this risk?	Only the Statewide Fiscal Intermediary will be allowed as the joint employer of the personal assistant.
1048	Subcontracting - Selection	Section 5.7: Subcontracting (Pages 15-16 of RFP)	The RFP requires the Statewide Fiscal Intermediary to consider compliance with federal and state laws in selecting subcontractors. Will the Department provide a specific list of eligible subcontractors, or will the Statewide Fiscal Intermediary have full discretion in making these selections?	Subcontracting arrangements are at the discretion of the Statewide Fiscal Intermediary provided they meet the requirements as outlined in the RFP. Subcontractors are subject to the approval of the Department.
1049	Subcontracting - Selection	Section 2.1: Background Information (Page 3 of RFP)	How will official subcontractor selection by the Statewide FI be communicated to the Department?	Per SSL 365-f, subcontractors are required to register with the Department. The specifics of the registration process have not yet been determined.
1050	Subcontracting - Selection	Section 2.1: Background Information (Page 3 of RFP)	Will subcontracts have to be in place before the contract between the Department and the Statewide FI is executed?	No.
1051	Subcontracting - Selection	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Can the State share the evaluation criteria for subcontractor review and approval?	The specific components of the Department's evaluation will not shared with the bidding community.
1052	Subcontracting - Selection	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Given that recent FOIL requests from various entities seeking a list of eligible subcontractors or Fiscal Intermediaries operating prior to January 1, 2012, have resulted in the Department stating that such a list does not exist and that these records could not be located, how will the Department accurately determine which entities qualify as eligible subcontractors? Does the Department currently possess information on eligible subcontractors, and if so, can it provide a comprehensive list to ensure transparency and fairness in the selection process? How will the Department ensure that all potential subcontractors are fairly considered and that the selection process is conducted without bias or with lack of appropriate records/information?	This question is not relevant to the development of a proposal under this RFP.
1053	Subcontracting - Selection	Section 5.7: Subcontracting (Pages 15-16 of RFP)	The RFP, in contrast to the RFP repealed in the SFY 2025 budget, does not provide information about the application process to become a subcontractor under a single fiscal intermediary applicant. Can you please clarify the process or justification for its absence?	This question is not relevant to the development of a proposal under this RFP.
1054	Subcontracting - Selection	Section 5.7: Subcontracting (Pages 15-16 of RFP)	The RFP says DOH must approve any subcontracting arrangements and can make a contingent award pending DOH review and approval of subcontracting agreements in its sole discretion. Because the bids may be highly dependent on the selected subcontractor(s), are there factors DOH will use to evaluate the appropriateness of subcontractors so that the bidder can evaluate potential subcontractors with such criteria in mind?	Per SSL 365-f, subcontractors are required to register with the Department. The specifics of the registration process have not yet been determined.
1055	Subcontracting - Selection	Section 5.7: Subcontracting (Pages 15-16 of RFP)	If a subcontractor is specified within the successful bidder's proposal but subsequently fails to obtain Departmental approval, how will this discrepancy between the awarded Statewide FI's agreed-upon contract (including their proposal) be navigated and amended?	This question is not relevant to the development of a proposal under this RFP.

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1056	Subcontracting - Selection	Section 5.7: Subcontracting (Pages 15-16 of RFP)	What is the timeline for the Single FI awardee to show proof of subcontracting agreements after the award date?	This question is not relevant to the development of a proposal under this RFP.
1057	Subcontracting - Selection	Section 5.7: Subcontracting (Pages 15-16 of RFP)	What are the criteria for evaluating and approving subcontractor agreements?	The specific components of the Department's evaluation will not be shared with the bidding community. The subcontractor agreement approval process is not relevant to the development of a proposal under this RFP.
1058	Subcontracting - Selection	Section 5.7: Subcontracting (Pages 15-16 of RFP)	What process will be established by DOH for regional subcontractor review, interview, subcontractor RFP completion for establishment of qualification and selection by the Single FI awardee?	This question is not relevant to the development of a proposal under this RFP.
1059	Subcontracting - Selection	Section 5.7: Subcontracting (Pages 15-16 of RFP)	What role will DOH play in selection of regional subcontractors?	This question is not relevant to the development of a proposal under this RFP.
1060	Subcontracting - Selection	Section 5.7: Subcontracting (Pages 15-16 of RFP)	What role will labor play in selection of regional subcontractors?	This question is not relevant to the development of a proposal under this RFP.
1061	Subcontracting - Selection	Section 5.7: Subcontracting (Pages 15-16 of RFP)	What process and criteria will DOH use to review and approve subcontracts? Can a subcontractor invoke DOH review of proposed subcontract terms? What terms will DOH require subcontracts to contain? What terms will DOH prohibit from subcontracts? What period of time will DOH require subcontracts to cover? What subcontract termination provisions will DOH require or approve? What subcontract renewal provisions will DOH require or approve? Under what conditions or terms may a single FI add, change or remove subcontractors? What criteria or process will the DOH utilize to respond to a single FI's request to the Department to add, change or remove subcontractors? What due process rights are afforded to a subcontractor that is subject to removal based on the Department's reservation of rights?	The specific components of the Department's evaluation will not be shared with the bidding community. The subcontractor agreement approval process is not relevant to the development of a proposal under this RFP.
1062	Subcontracting - Selection	Section 5.7: Subcontracting (Pages 15-16 of RFP)	This section states that the "Department will work with the awarded Statewide FI to review and approve subcontractor arrangements . . ." Please clarify what that means. Will the Department be approving the agreements between the awarded Statewide Fiscal Intermediary and its subcontractors? If so, what will that approval process entail and please list all criteria that will be used for review and approval. Similarly, separate from the subcontracts, will the Department be approving subcontractors? If so, what will that approval process entail and please list all criteria that will be used for review and approval.	The specific components of the Department's evaluation will not be shared with the bidding community. The subcontractor agreement approval process is not relevant to the development of a proposal under this RFP.
1063	Taxes	Section 6.3: Cost Proposal (Pages 24-25 of RFP)	Are there specific corporate tax considerations for businesses participating in this RFP?	Bidders should consult their own tax advisement professional for this question.
1064	Taxes	Section 6.3: Cost Proposal (Pages 24-25 of RFP)	Will the Statewide FI be required to pay the Gross Receipt Tax?	Bidders should consult their own tax advisement professional for this question.
1065	Taxes	Section 6.3: Cost Proposal (Pages 24-25 of RFP)	Should corporate taxes anticipated to be paid by the Statewide FI be included in the Administrative Cost proposal?	Bidders should consult their own tax advisement professional for this question.
1066	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Does the responsibility to complete training requirements for the PA fall to the Statewide FI or to the consumer?	Specific training related to the personal assistant's ability to carry out the tasks for the consumer based on the plan of care will continue to be the responsibility of the consumer. Other training as may be standardized and required by the Department would be the responsibility of the Statewide Fiscal Intermediary, to be carried out by it and/or its subcontractors. The implementation and specifics of any standardized training for personal assistants are still being determined.
1067	Training	General	What are the specific training requirements for staff to ensure compliance with the Department's standards and policies?	See answer to Question #1066
1068	Training	General	I understand that the PA may need mandated trainings. Will these new trainings include or require skilled tasks such as tube feedings, injections, etc? Is this something that is being provided and paid for by the DOH?	See answer to Question #1066
1069	Training	Section 2.1: Background Information (Page 3 of RFP)	How will the Department ensure that services to support and educate consumers are satisfactorily provided, and how will compliance be tracked?	See answer to Question #1066

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1070	Training	Section 2.1: Background Information (Page 3 of RFP)	The statute (SOS § 365-f) emphasizes the provision of support and education to consumers and personal assistants, including peer support, which is not detailed in the regulation (18 NYCRR 505.28). How will the Department ensure that these support and educational services are provided, and what specific criteria will be used to evaluate compliance?	See answer to Question #1066
1071	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet b) (Page 5 of RFP)	FI services shall not include fulfillment of training. If training and other requirements are established pursuant to authority granted in the NYS 24-25 Budget language, what party will be responsible for complying with and funding such training or other requirements? If PAs are required to participate in training, the time in training would be a cost under FLSA.	See answer to Question #1066
1072	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Does the training requirements for the PA fall to the Statewide FI or to the consumer?	See answer to Question #1066
1073	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet b) (Page 5 of RFP)	Will the consumer be required to cover specific topics of training?	See answer to Question #1066
1074	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	What will be covered in the training of PAs?	See answer to Question #1066
1075	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	How long will the training take for completion?	See answer to Question #1066
1076	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Will the training occurred before or after the background check?	See answer to Question #1066
1077	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Can you provide details on the mandatory training programs for personal assistants and how the Statewide FI should manage this training?	See answer to Question #1066
1078	Training	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	What training requirements apply to PAs?	See answer to Question #1066
1079	Training	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	May the selected FI establish PA training standards?	See answer to Question #1066
1080	Training	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	May the selected FI review whether a PA meets those training standards?	See answer to Question #1066
1081	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	4.1.e states the FI must also maintain records of completed training requirements. What training requirements are required for PAs in the CDPAP program?	See answer to Question #1066
1082	Training	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Section 4.1 (e) refers to completed training requirements for PAs. What training requirements are being referenced?	See answer to Question #1066
1083	Training	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Who is responsible for executing the training for PAs? What steps are being taken to ensure that any training requirements do not further bottleneck the availability of services?	See answer to Question #1066

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1084	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet b) (Page 5 of RFP)	The responsibility of consumer to "train" is in conflict with the obligations of the requirements of 4.1 (e) which calls for the Statewide FI to "train" the PA. Which obligation to "train" takes priority?	See answer to Question #1066
1085	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet j) (Page 5 of RFP)	This requirement is very open ended. Can bidders assume that new or expanded regulations by either the DOH Commissioner or CMS will be handled with a change management request?	See answer to Question #1066
1086	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Are there specific training materials or orientation processes that the Department recommends or requires for personal assistants, as outlined in Section 4.1 of the RFP?	See answer to Question #1066
1087	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet b) (Page 5 of RFP)	The responsibility of consumer to "train" is in conflict with the obligations of the requirements of 4.1 (e) which calls for the Statewide FI to "train" the PA. Which obligation to "train" takes priority?	See answer to Question #1066
1088	Training	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	"Fiscal Intermediaries are not responsible for, and fiscal intermediary services shall not include fulfillment of the responsibilities of the consumer. Responsibilities of the consumer (or designated representative) include: b) Training, scheduling and supervising PAs including arranging and scheduling substitute coverage when a PA is temporarily unavailable for any reason;" If awarded and the entity does provide annual training to the PA, what are the repercussions to the entity?	See answer to Question #1066
1089	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet b) (Page 5 of RFP)	How will conflicts preamble between the different trainings?	See answer to Question #1066
1090	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	CDPA's under current requirements did not need to be certified or background checked under DOH requirements. Please clarify "where applicable" the need for training or background checks.	See answers to Questions #1066 and #36
1091	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	RFP Section 4.1 Paragraph E): "Maintaining personnel records for each PA, including time records and other documentation needed for wages and benefit processing and a copy of the medical documentation required above by 4.1(b), as well as documentation, where applicable, of completed background checks and completed training requirements:" Please clarify the meaning of background checks as currently the only requirement is the Medicaid Exclusion List check. Please clarify the training requirements as currently they include TB education and Sexual Harassment – is there other mandatory training?	See answers to Questions #1066 and #36
1092	Training	Section 2.1: Background Information (Page 3 of RFP)	Can you provide more detailed definitions of "consumer peer support" and "education and training" as required services, as outlined in Section 2.1 of the RFP?	See answers to Questions #1066 and #729
1093	Training	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Does the FI contractor have responsibilities for consumer training other than use of their EVV application use? If so, please define the responsibilities.	See answer to Question #1066. The Statewide Fiscal Intermediary is responsible for training consumers and personal assistants on the use of the chosen EVV system.
1094	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet b) (Page 5 of RFP)	Will payment for training be provided to the potential PA be covered by the statewide FI?	See answer to Question #1066. The cost of training not yet determined should not be factored into a bidder's cost proposal.
1095	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet b) (Page 5 of RFP)	If payment for training is available, how much?	See answer to Question #1066. The cost of training not yet determined should not be factored into a bidder's cost proposal.
1096	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet b) (Page 5 of RFP)	Is payment for training paid by the hour?	See answer to Question #1066. The cost of training not yet determined should not be factored into a bidder's cost proposal.
1097	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet b) (Page 5 of RFP)	Will the consumer need to get permission to use payment for training?	See answer to Question #1066. The cost of training not yet determined should not be factored into a bidder's cost proposal.

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1098	Training	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	Will the selected FI be required to compensate PAs for any time spent training?	See answer to Question #1066. The cost of training not yet determined should not be factored into a bidder's cost proposal.
1099	Training	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet h) (Pages 7-8 of RFP)	If the selected FI is required to compensate PAs for any time spent training, will the Department reimburse the selected FI for any time spent training?	See answer to Question #1066. The cost of training not yet determined should not be factored into a bidder's cost proposal.
1100	Training	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Will the new statewide FI assume liability for any injuries which occur as a result of information presented in PA training?	The selected bidder will be responsible for complying with all applicable laws, rules, and regulations, both state and federal and will be subject to the corresponding applicable sanctions and penalties. Each bidder should consult with its advisors to determine legal obligations and liabilities under the contract.
1101	Transition	Section 4.10: Transition Requirements, Paragraph 2 (Page 11 of RFP)	If additional unanticipated costs are incurred during the transition to the Statewide FI, what measures will be implemented by the Department to ensure programmatic availability and sustainability for existing program users?	See Amendment #3 to the RFP. A Transition Cost PMPM has been included in the Cost Proposal Form. No other costs outside those in the revised Cost Proposal will be allowed.
1102	Transition	Section 4.10: Transition Requirements (Page 11 of RFP)	Will the Department provide any funding for the transition from current FIs to the awarded contractor?	See Amendment #3 to the RFP.
1103	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Who will bear the costs of those records transfers?	See Amendment #3 to the RFP.
1104	Transition	Section 4.10: Transition Requirements, Paragraph 1 (Page 11 of RFP)	Section 4.10 details the transition period at the end of the contract, but there is not mention of a transition period towards a Single FI. Who is responsible for the transition costs of moving towards a Single FI?	See Amendment #3 to the RFP.
1105	Transition	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	How will the Department assess and verify that an SFI with out-of-state experience possesses the necessary expertise and infrastructure to seamlessly transition into providing New York-specific fiscal intermediary services, which include unique statutory and regulatory requirements?	Bidders will be expected to understand and comply with New York's rules and regulations for Fiscal Intermediary services.
1106	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	If the contract with the statewide FI begins October 1, 2024, when will consumers and PA's be transitioned to the statewide FI from current FIs?	Upon selection of a vendor, the Department will work with the contracted statewide fiscal intermediary, managed care plans, Local Departments of Social Services, and other stakeholders to develop and implement a transition plan and timeline to ensure all consumers and personal assistants are transitioned seamlessly to the new fiscal intermediary including, but not limited to, the transfer of personal assistant documentation.
1107	Transition	General	When will the Department meet with providers, advocates, and consumers to discuss this transition?	See answer to Question #1106
1108	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	If the selected FI is not responsible for contacting each Consumer, who will contact the Consumer and/or Personal Assistant?	See answer to Question #1106
1109	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	What is the projected date for the FI services to go live statewide, i.e. what is the project implementation schedule?	See answer to Question #1106
1110	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	Will the selected FI be responsible for providing any required notices to current Consumers and, if so, when will these notices be provided?	See answer to Question #1106
1111	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	Will the selected FI be responsible for contacting each Consumer and/or Personal Assistant?	Yes. See answer to Question #1106
1112	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	Will the Department of Health (hereinafter "Department of Health" or "Department") make available a list of current Consumers and/or Personal Assistants to the awardee and, if so, when will such list(s) be made available?	See answer to Question #1106
1113	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	What process does the state plan to use to facilitate system transition and administrative onboarding? By what date is the Bidder expected to be fully operational?	See answer to Question #1106

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1114	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	What does the October 1st award date mean for existing FI's?	See answer to Question #1106
1115	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	What is the timeline once the contract is awarded to transition existing FIs and consumers to this model?	See answer to Question #1106
1116	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	What is the expected timeline from the contract start date to the program start date?	See answer to Question #1106
1117	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	When will the transition of CDPAP consumers from current FIs to the awarded Statewide FI begin? Could you please provide the specific date?	See answer to Question #1106
1118	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	Will the transition of consumers to the awarded Statewide FI begin in October 2024?	See answer to Question #1106
1119	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	Social Services Law § 365-f(4-a-1)(a) states, "Except for the statewide fiscal intermediary and its subcontractors, as of April first, two thousand twenty-five, no entity shall provide, directly or through contract, fiscal intermediary services." If the start date of the contract for the awarded Statewide Fiscal Intermediary is October 1, 2024, as the Department anticipates, can entities currently performing FI services in New York State which are not the Statewide Fiscal Intermediary or one of its subcontractors continue to provide fiscal intermediary services in New York State up to March 31, 2025?	See answer to Question #1106
1120	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	What guardrails have been put in place to prevent any gap in services during this transition period?	See answer to Question #1106
1121	Transition	Section 2.1: Background Information, Paragraph 3 (Page 3 of RFP)	The statute New York Consolidated Laws, Social Services Law, SOS § 365-f stipulates that aside from the selected Statewide FI and its subcontractors, no entity shall provide fiscal intermediary services in New York State as of April 1, 2025. Will the Department provide a formal transition plan following the Statewide FI award decision to facilitate the program's transition by this specified date?	See answer to Question #1106
1122	Transition	Section 2.1: Background Information (Page 3 of RFP)	How will the disruptions in services and potential job losses be avoided?	See answer to Question #1106
1123	Transition	Section 2.1: Background Information (Page 3 of RFP)	How will the Department mitigate disruptions in services and potential job losses?	See answer to Question #1106
1124	Transition	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	How will consumers/PAs be transitioned and to what entity if DOH terminates the contract with the single FI?	See answer to Question #1106
1125	Transition	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Knowing that entities performing services in other states mainly administer similar programs as a Fiscal/Employer Agent (F/EA), which includes establishing the consumer with their own, unique and separate Employer Identification Number (EIN), how will the Department ensure that such an SFI fully comprehends and complies with the nuanced responsibilities and regulatory framework that are specific to New York State's CDPA program, thereby avoiding potential discrepancies and disruptions in service delivery to New York consumers?	See answer to Question #1106
1126	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Are current FIs obligated to provide PA documentation regarding wages and benefits to the awarded FI?	See answer to Question #1106
1127	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet d) (Page 5 of RFP)	Are current FIs obligated to provide PA documentation regarding health status (for example, certificates of immunization, annual health status assessment) to the awarded FI?	See answer to Question #1106
1128	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet d) (Page 5 of RFP)	Do existing PAs have health assessments, and will those health assessments be transferred to the new fiscal intermediary?	See answer to Question #1106

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1129	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Do current FIs maintain personnel records for each PA? If yes, will those records transfer to the new fiscal intermediary?	See answer to Question #1106
1130	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	What is the process for this transfer?	See answer to Question #1106
1131	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Will current fiscal intermediaries be required to transfer such records?	See answer to Question #1106
1132	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet e) (Page 5 of RFP)	Will the state ensure that the SFI will receive existing PAs' employment history and qualifications from current FI agencies?	See answer to Question #1106
1133	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet f) (Page 5 of RFP)	Do current FIs maintain consumer records for each consumer? If yes, will those records transfer to the new fiscal intermediary?	See answer to Question #1106
1134	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet f) (Page 5 of RFP)	What happens if a consumer does not provide an appropriate HIPAA authorization to transfer records?	See answer to Question #1106
1135	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet f) (Page 5 of RFP)	Do current FIs maintain copies of service authorizations or reauthorizations?	See answer to Question #1106
1136	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet f) (Page 5 of RFP)	If current FIs maintain copies of service authorizations or reauthorizations, will those records transfer to the new fiscal intermediary?	See answer to Question #1106
1137	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet f) (Page 5 of RFP)	Will current fiscal intermediaries be required to transfer such records?	See answer to Question #1106
1138	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet f) (Page 5 of RFP)	What happens if these records are not available from the existing fiscal intermediary?	See answer to Question #1106
1139	Transition	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP) and Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	How will the Department address potential delays in the Medicaid enrollment process for an out-of-state SFI, and what contingency plans are in place to ensure uninterrupted service delivery during this period?	See answer to Question #1106
1140	Transition	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet a) (Page 8 of RFP)	Will the selected FI be expected to serve all eligible Consumers in the State as of April 1, 2025?	See answer to Question #1106
1141	Transition	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet a) (Page 8 of RFP)	What will be an acceptable period of time for the selected FI to enroll a Consumer?	See answer to Question #1106
1142	Transition	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet a) (Page 8 of RFP)	What will be an acceptable period of time for the selected FI to enroll a PA?	See answer to Question #1106
1143	Transition	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet a) (Page 8 of RFP)	What relief will be available to a Consumer in the event that there is a delay in enrolling a PA?	See answer to Question #1106

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1144	Transition	Section 4.7: Quality Monitoring and Reporting Requirements, Paragraph 1 (Page 9 of RFP)	How will the Department assist the Statewide FI in coordination with Local Departments of Social Services (LDSS) and Managed Care Organizations (MCOs) to ensure seamless service delivery?	See answer to Question #1106
1145	Transition	Section 4.9: Privacy, Security and Confidentiality Requirements (Pages 10-11 of RFP)	Is a losing bidder required to destroy client and PA documentation? What specific information needs to be destroyed, and what is the approved method of destruction? If the losing bidder does not have to provide this information or destroy it, is there a retention period that must be adhered to?	See answer to Question #1106
1146	Transition	Section 4.10: Transition Requirements (Page 11 of RFP)	When will transition timelines and policies be publicly available?	See answer to Question #1106
1147	Transition	Section 4.10: Transition Requirements (Page 11 of RFP)	What steps will be taken if transitions are not completed by the April 1, 2025, deadline?	See answer to Question #1106
1148	Transition	Section 4.10: Transition Requirements (Page 11 of RFP)	What is the division of responsibilities and liabilities between the single FI and subcontractors in the general transition activities described in this section? Will DOH allow the single FI to transfer this risk to subcontractors? Will DOH allow indemnification provisions in subcontracts related to this risk? What is the consequence if transition does not occur on the state's timeline due to matters beyond the control of the single FI and/or the subcontractors?	See answer to Question #1106
1149	Transition	Section 4.10: Transition Requirements, Paragraph 1 (Page 11 of RFP)	Section 4.10 details the transition period at the end of the contract, but there is not mention of a transition period towards a Single FI. When can current FIs and Consumers expect that a plan of transition would be provided?	See answer to Question #1106
1150	Transition	Section 4.10: Transition Requirements, Paragraph 1 (Page 11 of RFP)	RFP Section 4.10 Paragraph 2, "In addition to complying with the transition requirements provided in § 365-f (4-d) and any directives or guidance the Department may issue to facilitate a transition, the awarded Statewide FI and its subcontractors shall generally ensure that any transition to the Department, Departmental agent, or successor Statewide FI be done in a way that provides the Department with uninterrupted FI administrative functions and responsibilities as currently required under statute and regulation for FI services. This includes a complete and total transfer of all data, files, reports, and records generated from the inception of the contract through the end of the contract to the Department or another Department agent should that be required during or upon expiration of its contract. How is the Statewide to ensure uninterrupted CDPAP Service if there is no requirement for current Fiscal Intermediaries to transfer records especially, PA medical records considering HIPAA confidentiality laws? When will DOH issue guidance to current FIs?	See answer to Question #1106
1151	Transition	Section 4.10: Transition Requirements, Paragraph 2 (Page 11 of RFP)	What recourse does the department of the Statewide FI have if current fiscal intermediaries fail to turn over necessary data, files, reports, and records as outlined in this section?	See answer to Question #1106
1152	Transition	Section 4.10: Transition Requirements, Paragraph 2 (Page 11 of RFP)	How will the transition process be managed if April 1st, 2025, occurs before the new Statewide FI is fully operational?	See answer to Question #1106
1153	Transition	Section 4.10: Transition Requirements (Page 11 of RFP)	Section 4.10 details the Statewide FI's turnover procedure during or at the end of the Statewide FI's contract. However, it is silent as to the turnover procedure for current FIs to the new Statewide FI. For instance, will the Statewide FI take over contracts directly from current FIs, or will the records and/or services be managed by the DOH at any point? Will the Statewide FI take over any existing FI contracts prior to April 1, 2025?	See answer to Question #1106
1154	Transition	Section 4.10: Transition Requirements (Page 11 of RFP)	How will the State ensure that there are no disruption in home care services to the consumer during this transition, and is that the responsibility of the single statewide FI?	See answer to Question #1106

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1155	Transition	Section 4.10: Transition Requirements (Page 11 of RFP)	Section 4-d ("Fiscal intermediaries ceasing operation") of Section 365-F of Social Services (SOS) Chapter 55, Article 5, Title 11 governs the cessation of operations of an FI, including transition of services and transfer of records. Will DOH enforce the provisions of Section 4-d with respect to the cessation of operations of existing FIs in favor of the Statewide FI as of April 1, 2025? For example, will each relevant local social services district or managed care plan, as appropriate, be expected to "supervise the transition of services and transfer of records and maintain provision of services by the personal assistant(s) chosen by the individual"? How will DOH ensure that "[a]ny transfer under this subdivision shall not diminish any of an individual's rights relating to continuity of care, utilization review or fair hearing appeals and aid continuing"? Information regarding how and when the services, contracts, and records of existing FIs will transition to the Statewide FI is necessary in order for existing FIs to prepare for a seamless transition in services.	See answer to Question #1106
1156	Transition	Section 4.10: Transition Requirements, Paragraph 1 (Page 11 of RFP)	The RFP includes language on the transition of consumers at the end of the contract. What is the process for the transition of consumers to the Statewide FI once the contract is awarded?	See answer to Question #1106
1157	Transition	Section 4.10: Transition Requirements, Paragraph 1 (Page 11 of RFP)	When will a plan of transition would be provided and what is the process for the transition of consumers to the Statewide FI?	See answer to Question #1106
1158	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	What specific steps will the Department take to ensure a seamless transition upon contract commencement from the current multi-FI model to a single statewide FI, particularly for consumers who rely on continuous and uninterrupted care?	See answer to Question #1106
1159	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	What are the specific timelines and milestones for the transition process from existing FIs (who are not subcontracting with the SFI) to the awarded SFI? Section 4.10	See answer to Question #1106
1160	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	How will the Department address risks to consumers and personal assistants if the transition is not completed by the target date?	See answer to Question #1106
1161	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	What are the specific timelines and milestones for the transition process from existing FIs (who are not subcontracting with the SFI) to the awarded SFI, and how will the Department ensure adherence to these timelines to prevent service disruption?	See answer to Question #1106
1162	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	What contingency plans are in place to address potential delays in the transition process, and how will the Department mitigate risks to consumers and personal assistants if the transition is not completed by the target date?	See answer to Question #1106
1163	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	How will the Department address potential disruptions in service during the transition period applicable to the contract's commencement, and what contingency plans are in place to mitigate risks for consumers and personal assistants?	See answer to Question #1106
1164	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	What specific requirements are in place for existing FIs to provide consumer and personal assistant information for the transition to the awarded SFI, considering the existing FI's ownership and rights of this information?	See answer to Question #1106
1165	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	Will there be a reimbursement mechanism for the existing FIs for the time, effort, and cost incurred in providing data and support during the transition process to the awarded SFI, either by the State or the awarded SFI?	See answer to Question #1106
1166	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	Considering the over 500 existing FIs each utilizing different system platforms, how does the Department plan to ensure that consumer and personal assistant information will be efficiently and effectively transitioned to the awarded SFI without causing any service disruptions?	See answer to Question #1106
1167	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	What measures will be implemented to ensure data security and privacy during the transition of consumer and personal assistant information, specific concerning the existing FIs who are not subcontracting with the awarded SFI?	See answer to Question #1106

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1168	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	What support mechanisms will be in place for consumers and personal assistants during the transition period to address any issues or concerns that may arise?	See answer to Question #1106
1169	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	How will the Department ensure that all personal assistants and consumers are adequately trained and oriented to the new systems and processes implemented by the awarded SFI?	See answer to Question #1106
1170	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	How will the Department facilitate coordination between the awarded SFI and Local Departments of Social Services (LDSS) to ensure a seamless transition and continuous service delivery?	See answer to Question #1106
1171	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	What monitoring and accountability measures will be established to ensure that the awarded SFI and existing FIs comply with all transition requirements and timelines?	See answer to Question #1106
1172	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	Will there be mechanisms for collecting feedback from consumers, personal assistants, and existing FIs during the transition process, and how will this feedback be used to make necessary adjustments and improvements?	See answer to Question #1106
1173	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	What legal and compliance considerations will be addressed to ensure that the transition process adheres to all federal, state, and local regulations, and how will potential legal challenges be managed?	See answer to Question #1106
1174	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	What is the communication strategy to inform all stakeholders, including consumers, personal assistants, and existing FIs, about the transition process, timelines, and any changes in service delivery?	See answer to Question #1106
1175	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	How will the Department evaluate the success of the transition process, and what metrics will be used to determine if the transition has been completed effectively and without disrupting services?	See answer to Question #1106
1176	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	How will the Department address potential system integration challenges that may arise from merging data and operations from over 500 different FIs into a single SFI platform?	See answer to Question #1106
1177	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	How will the Department ensure that consumer choice and autonomy are preserved during and after the transition to a single SFI, given the diversity of needs and preferences among the consumer population?	See answer to Question #1106
1178	Transition	Section 4.10: Transition Requirements, Paragraph 4 (Page 11 of RFP)	What is the risk management strategy for the transition process, and how will potential risks be identified, assessed, and mitigated to protect consumer services and personal assistant employment?	See answer to Question #1106
1179	Transition	Section 4.10: Transition Requirements (Page 11 of RFP)	What are the requirements of the contractor to ensure appropriate transition occurs between current FIs and the awarded contractor?	See answer to Question #1106
1180	Transition	Section 4.10: Transition Requirements (Page 11 of RFP)	What records will the awarded contractor be required to obtain from the current FIs?	See answer to Question #1106
1181	Transition	Section 4.10: Transition Requirements (Page 11 of RFP)	What if the awarded contractor's technology system(s) differ from those used by the current FIs?	See answer to Question #1106
1182	Transition	Section 5.6.1: Data Breach and Privacy/Cyber Liability including Technology Errors and Omissions (Page 14 of RFP)	Has the Department considered the high probability of errors, data loss, and service interruptions during the transition to a single or few CDPAP fiscal intermediaries? What contingency plans are in place to address these challenges? What measures will the Department take aside from Data Breach and Privacy/Cyber Liability insurance to address the increased risk of large-scale data breaches by consolidating all personal and health data of CDPAP consumers into a single entity?	See answer to Question #1106
1183	Transition	Section 6.2.F.3: Fiscal Intermediary Organizational Requirements (Page 23 of RFP)	Section 6.2.F.3 asks bidders to describe how they will "serve any consumer statewide." Does DOH expect that bids must be immediately operational across the state, or the entire population of consumers who will be served, or – given the scope of the transition – is there an allowance for bids that include a phase-in timeline?	See answer to Question #1106

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1184	Transition	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Given the unique cultural and linguistic landscape of New York State, does the Department anticipate any potential challenges or delays in service delivery by an out-of-state SFI? If so, what contingency plans are in place to address these issues?	See answer to Question #1106
1185	Transition	Section 4.1: Required Fiscal Intermediary Services, Bullet f) (Page 5 of RFP)	What contingencies are in place to protect workers in CDPAP from experiencing significant pay lags, as have been reported in other states, as the transition unfolds?	See answer to Question #1106
1186	Transition	General	What specific plans are in place to communicate with and transition the over 250,000 CDPAP consumers to the single FI by the April 1, 2025, deadline?	See answer to Question #1106
1187	Transition	General	What contingencies are in place to protect workers in CDPAP from experiencing significant pay lags, as have been reported in other states, as the transition unfolds?	See answer to Question #1106
1188	Transition	General	What plans are in place to ensure that beneficiaries' services are not disrupted during the transition? For consumers whose service disruptions lead to placement in skilled nursing facilities, how will the Department support their return to aging in the community once the disruption abates?	See answer to Question #1106
1189	Transition	General	Will consumers be notified of this transition, and if so, who is responsible for this notification? Secondly, what methods of notification are required/acceptable?	See answer to Question #1106
1190	Transition	General	Are FIs who do not win this award required to deliver existing documentation on clients and PAs to the winning bidder? If so, what is the appropriate delivery method for this information?	See answer to Question #1106
1191	Transition	General	If we are not awarded the lead role, what will be the status of our existing patients?	See answer to Question #1106
1192	Transition	General	What mechanism and processes will be established by DOH for Consumers to support seamless transition back to LHCSA services if need be?	See answer to Question #1106
1193	Transition	General	What turnover responsibilities does the current FI contractor have during transition from their contract to the new contract?	See answer to Question #1106
1194	Transition	General	What documentation do current FIs have to transfer to the awarded Statewide FI?	See answer to Question #1106
1195	Transition	General	Despite what the RFP says, is it likely that the rollout to a single FI be phased instead of implementing all at once?	See answer to Question #1106
1196	Transition	General	What responsibilities and requirements will the Statewide FI have with respect to transitioning Consumers from their current FI to the Statewide FI? a. Will DOH release new transition guidelines, including transfer of any records from FIs to the SFI? b. Are transition (or any other one-time costs) considered administrative costs that the Statewide FI should include in the Admin PMPM cost proposal? c. Should bidders submit a separate cost proposal for transitional activities and responsibilities that are not expected to be recurring costs under the new Statewide FI?	See answer to Question #1106
1197	Transition	General	What specific plans are in place to communicate with and transition the over 250,000 CDPAP consumers to the single FI by the April 1, 2025, deadline?	See answer to Question #1106
1198	Transition	General	When will the Department meet with providers, advocates, and consumers to discuss this transition?	See answer to Question #1106
1199	Transition	General	What plans are in place to ensure that beneficiaries' services are not disrupted during the transition? For consumers whose service disruptions lead to placement in skilled nursing facilities, how will the Department support their return to aging in the community once the disruption abates?	See answer to Question #1106
1200	Transition	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Given the unique cultural and linguistic landscape of New York State, does the Department anticipate any potential challenges or delays in service delivery by an out-of-state SFI? If so, what contingency plans are in place to address these issues?	See answer to Question #1106

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1201	Transition	Section 1.0: Calendar of Events (Page 3 of RFP)	Considering the unique complexities and responsibilities placed on FIs within the New York State CDPA program—distinct from the Fiscal/Employer Agent and budget authority model utilized by the majority of other states—and recognizing that New York has the second-largest CDPA program population in the nation (and the 3rd largest State is well under 100,000 consumers), what specific data and analysis did the Department use to develop this timeline? Additionally, how does the Department plan to ensure that the transition timeline aligns with the current statutory deadline (April 1, 2025) while guaranteeing no service disruptions that could compromise consumer health and safety, limit CDPA availability during the transition, or lead to the re-institutionalization of program users, thus potentially violating the Olmstead decision?	See answer to Question #1106
1202	Transition	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	How will the Department help in coordination with Local Departments of Social Services (LDSS) and Managed Care Organizations (MCOs) to ensure seamless service delivery?	See answer to Question #1106
1203	Union	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Are Personal Assistants currently unionized?	The Department does not have this information.
1204	Union	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Will the statewide FI (and each PA) be subject to a collective bargaining agreement? If so, (see 4.3), how should an FI develop a wage for each PA when wages may be subject to a collective bargaining agreement that is unknown at this time?	Unionization of personal assistants is not a requirement of the RFP and the Department will not opine on the topic.
1205	Union	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	If Personal Assistants are currently unionized, will the statewide fiscal intermediary be required to recognize their current union wages and benefits?	See answer to Question #1204
1206	Union	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Will the selected FI be required to have a collective bargaining agreement with a union?	See answer to Question #1204
1207	Union	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Will PAs be required to join a union?	See answer to Question #1204
1208	Union	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Will the Department favor offerors who are willing to accept a union?	See answer to Question #1204
1209	Union	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	How should an offeror indicate its willingness or lack of willingness to accept a union in its application?	See answer to Question #1204
1210	Union	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	What criteria will the Department use to evaluate whether an offeror is willing to accept a union?	See answer to Question #1204
1211	Union	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet f) (Pages 6-7 of RFP)	How can an FI coordinate PA benefits effectively with the possibility of a collective bargaining agreement impacting the FI?	See answer to Question #1204
1212	Union	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet g) (Pages 7-8 of RFP)	Is the Department suggesting that a bidder must enter into wage and labor agreements, including union contracts and collective bargaining agreements?	See answer to Question #1204
1213	Union	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet g) (Pages 7-8 of RFP)	Is the Department requiring that the successful bidder honor pre-existing wage and labor agreements, including union contracts and collective bargaining agreements?	See answer to Question #1204

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1214	Union	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet g) (Pages 7-8 of RFP)	Will the Department look more favorably upon a proposal in which a bidder says that it has a pre-existing wage and labor agreement, or union contract or collective bargaining agreement, or if the bidder states a willingness to enter into such contract or agreement?	See answer to Question #1204
1215	Union	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	In 4.4(g), the Statewide FI is identified as being responsible for complying with "Wage andlabor agreements, including union contracts and collective bargaining agreements." Is the Awarded Statewide FI responsible for honoring labor agreements with PAs who work for FIs that are currently unionized?	See answer to Question #1204
1216	Union	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet g) (Pages 7-8 of RFP)	Is there a requirement to contract with a Union?	See answer to Question #1204
1217	Union	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	In 4.4(g), the Statewide FI is identified as being responsible for complying with "Wage and labor agreements, including union contracts and collective bargaining agreements." Is it anticipated that PAs will be unionized as a part of the shift to a statewide fiscal intermediary?	See answer to Question #1204
1218	Unique ID	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet i) (Page 9 of RFP)	Should the PA unique identifier be included on the claims submitted to the insurance plans and the counties?	The implementation of the Unique Identifier for CDPAP personal assistants is still in development. Upon implementation, the Department will work with the Statewide Fiscal Intermediary on any specific requirements.
1219	Unique ID	Section 5.7: Subcontracting (Pages 15-16 of RFP)	Has a specific process been developed for Personal Assistants to register for a unique identifier as required by SSL 365-(f)3?	See answer to Question #1218
1220	WC/Disability	Section 4.1: Required Fiscal Intermediary Services, Bullet c) (Page 5 of RFP)	Regarding Workers Compensation, Disability Insurance and other Benefit requirements, will the FI be responsible for advancing the funds to purchase the benefits, or will the Department advance the estimated cost of these aforementioned benefits?	Virtually all employers in New York State must provide workers' compensation coverage (WCL §2 and 3), disability benefits and Paid Family Leave benefits coverage for their employees (WCL §202). The FI will be responsible for purchasing the required policies for such benefits.
1221	WC/Disability	Section 4.1: Required Fiscal Intermediary Services, Bullet c) (Page 5 of RFP)	Regarding worker's compensation, is the class code used for CDPAP 0917 or 9051?	The workers' compensation carrier will assign the class code using criteria set by the Compensation Insurance Rating Board (CIRB).
1222	WC/Disability	Section 4.1: Required Fiscal Intermediary Services (Page 5 of RFP)	Is the FMS contractor responsible for obtaining/ maintaining a Workers' Compensation policy for Employers?	See answer to Question #1221
1223	WC/Disability	Section 4.1: Required Fiscal Intermediary Services, Bullet c) (Page 5 of RFP)	Is workers compensation insurance coverage mandatory?	Yes.
1224	WC/Disability	Section 4.1: Required Fiscal Intermediary Services, Bullet c) (Page 5 of RFP)	Is the Fiscal Employer Agent contractor responsible for obtaining/maintaining a Workers' Compensation policy for Employers?	See answer to Question #1221
1225	WC/Disability	Section 4.1: Required Fiscal Intermediary Services, Bullet c) (Page 5 of RFP)	Is the Workers Compensation provided through individual polices per consumer or through an umbrella policy?	Employers provide coverage for their employees.
1226	WC/Disability	Section 4.1: Required Fiscal Intermediary Services, Bullet c) (Page 5 of RFP)	Is the FI contractor responsible for enrolling consumers in workers compensation insurance?	See answer to Question #1221
1227	WC/Disability	Section 5.7: Subcontracting, Paragraph 7, Bullet 1 (Pages 15-16 of RFP)	How will workers' compensation be paid for? Will it be deducted from the budget, paid for by the worker, paid via administrative billing and invoiced to the state or MCO, or paid out of the PMPM?	See answer to Question #1221
1228	WC/Disability	Section 4.1: Required Fiscal Intermediary Services, Bullet c) (Page 5 of RFP)	Regarding worker's compensation, what is the valued loss information for CDPAP for the last 5 years plus current?	The Department does not have this information.

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1229	WC/Disability	Section 4.1: Required Fiscal Intermediary Services, Bullet c) (Page 5 of RFP)	Regarding disability insurance, PFL portion of the disability contract is predicted on payroll. What is the average annual gross payroll per consumer?	The Department does not have this information.
1230	WC/Disability	Section 4.1: Required Fiscal Intermediary Services, Bullet d) (Page 5 of RFP)	Regarding disability insurance, what is the loss information for the last 5 years?	The Department does not have this information.
1231	WC/Disability	Section 4.1: Required Fiscal Intermediary Services, Bullet c) (Page 5 of RFP)	What are workers' compensation, disability and unemployment requirements that the fiscal intermediary is responsible for, what is the current cost of these requirements, and will the Department, managed care plans, managed long-term care plans, Local Departments of Social Services, and other appropriate long-term service programs offering consumer directed personal assistance services be required to reimburse the fiscal intermediary for these costs?	See answer to Question #1221
1232	Website	Section 4.2: Best Practices, Bullet f) (Page 6 of RFP)	Please define "their identified supports" as such term is ambiguous.	"Identified supports" in this context means a consumer's identified supports such as a designated representative or family member.
1233	Website	Section 4.2: Best Practices, Bullet f) (Page 6 of RFP)	How will the Department ensure that "identified support" is not creating a joint employer obligation of the consumer?	See answer to Question #1232
1234	Website	Section 4.2: Best Practices (Page 6 of RFP)	Who will be held responsible if the website or email system is not ADA compliant?	The Statewide Fiscal Intermediary will be responsible for meeting its obligations under the resulting contract.
1235	Website	Section 4.2: Best Practices (Page 6 of RFP)	Who will be held responsible if the website or email system is not maintained?	See answer to Question #1232
1236	Website	Section 4.2: Best Practices (Page 6 of RFP)	Will DOH monitor the consumer satisfaction with the email system or website of the statewide FI?	The Statewide Fiscal Intermediary should have a method by which consumers and personal assistants may voice dissatisfaction with the website. Reporting by the Statewide Fiscal Intermediary to the Department has not been determined at this time.
1237	Website	Section 4.2: Best Practices, Bullet f) (Page 6 of RFP)	RFP Section 4.2 Paragraph F: "f) Establishing, maintaining, and monitoring an electronic email or an ADA compliant, user-friendly website that provides information to consumers and their identified supports and provide a means to report and/or resolve complaints and answer inquiries." Please provide example of ADA compliant means for individuals with vision impairment such as the blind?	See https://www.ny.gov/accessibility and NYS P08-005 Accessibility of Web Based Information and Applications
1238	Website	Section 4.2: Best Practices, Bullet f) (Page 6 of RFP)	What is an "ADA compliant, user-friendly website"?	See https://www.ny.gov/accessibility and NYS P08-005 Accessibility of Web Based Information and Applications
1239	Website	Section 4.2: Best Practices, Bullet f) (Page 6 of RFP)	Is it the Department's view that the ADA applies to websites?	See https://www.ny.gov/accessibility and NYS P08-005 Accessibility of Web Based Information and Applications
1240	Website	Section 4.2: Best Practices (Page 6 of RFP)	The RFP states that bidders may use creative approaches to assist in the delivery of high quality FI services. Among the best practices is "Establishing, maintaining, and monitoring an electronic email or an ADA compliant, user-friendly website that provides information to consumers and their identified supports and provide a means to report and/or resolve complaints and answer inquiries." Does this mean that bidders may have websites for consumers that are not ADA compliant or user-friendly as long as they do not identify such website in their best practices?	No.
1241	Modification Request	Section 4.0: Scope of Work (Page 5 of RFP)	**Request:** Modify subcontractor experience for NYC Region from January 1, 2012 to January 1, 2018 which would represent 5 years of service provision experience.	The Department will not make this modification to the RFP.
1242	Modification Request	Section 4.0: Scope of Work (Page 5 of RFP)	**Request**: Expand the minimum number of required subcontractors to a minimum of 3 to a maximum of 5 per NYS DOH MLTC rate setting region.	The Department will not make this modification to the RFP.
1243	Modification Request	Section 4.5 Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	**Request**: Eliminate the LHCSA/FI ownership and control preclusion for subcontracting.	The Department will not make this modification to the RFP.
1244	2012 Requirement	Section 4.0: Scope of Work, Paragraph 1 (Page 5 of RFP)	How will NYS determine which fiscal intermediaries were in operation since January 1, 2012 or earlier?	This question is not relevant to the development of a proposal under this RFP.

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1245	2012 Requirement	Section 4.0: Scope of Work, Paragraph 1 (Page 5 of RFP)	Will DOH provide a definition of "in operation" to mean filing of a specific incorporation document by January 1, 2012?	This question is not relevant to the development of a proposal under this RFP.
1246	Advisory Committee	Section 4.2: Best Practices, Bullet e) (Page 6 of RFP)	Why has DOH made this optional?	This question is not relevant to the development of a proposal under this RFP.
1247	Auditing	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet i) (Pages 6-7 of RFP)	How often will a consumer receive the results of such auditing of billing records?	This question is not relevant to the development of a proposal under this RFP.
1248	Auditing	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet i) (Pages 6-7 of RFP)	Will a consumer have the opportunity to contest or explain the results of the auditing of billing records?	This question is not relevant to the development of a proposal under this RFP.
1249	Auditing	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet i) (Pages 6-7 of RFP)	Will consumers receive a detailed description of billing records auditing process?	This question is not relevant to the development of a proposal under this RFP.
1250	Auditing	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements, Bullet i) (Pages 6-7 of RFP)	Does the auditing of consumer billing records average out overtime hours over an entire care team of the individual?	This question is not relevant to the development of a proposal under this RFP.
1251	Award	Section 1.0: Calendar of Events (Page 3 of RFP)	Will DOH delay implementation of the Statewide FI if a contractor has been awarded?	This question is not relevant to the development of a proposal under this RFP.
1252	Award	Section 8.7: Award Recommendation (Page 27 of RFP)	Will the NYS Comptroller or any other office be required to review and approve the applicant selected by the Department for the contract award?	This question is not relevant to the development of a proposal under this RFP.
1253	Award	Section 8.7: Award Recommendation (Page 27 of RFP)	Is the Commissioner required to accept the recommendation of the Evaluation Committee?	This question is not relevant to the development of a proposal under this RFP.
1254	Award	Section 8.7: Award Recommendation (Page 27 of RFP)	If the Commissioner is not required to accept the recommendation of the Evaluation Committee, on what basis may the Commissioner reject the recommendation of the Evaluation Committee?	This question is not relevant to the development of a proposal under this RFP.
1255	Award	Section 8.7: Award Recommendation (Page 27 of RFP)	Will anyone other than the Evaluation Committee advise the Commissioner on the bid to be awarded?	This question is not relevant to the development of a proposal under this RFP.
1256	Award	Section 8.7: Award Recommendation (Page 27 of RFP)	May the Commissioner accept advice or recommendation from anyone other than the Evaluation Committee?	This question is not relevant to the development of a proposal under this RFP.
1257	Award	Section 8.7: Award Recommendation (Page 27 of RFP)	May a disappointed bidder appeal the award decision?	This question is not relevant to the development of a proposal under this RFP.
1258	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	How did the Department determine that the practices described in this section are best practices?	This question is not relevant to the development of a proposal under this RFP.
1259	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	Can the Department provide the specific statute and/or regulation sections and language that explicitly align with the best practices stated in RFP Section 4.2? A review of the current CDPAP statute and regulations does not reveal any best practice requirements or language corresponding to this section of the RFP.	This question is not relevant to the development of a proposal under this RFP.
1260	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	If there are no specific statutory or regulatory references for the best practices outlined in Section 4.2, what legal authority does the Department have to enforce these best practices on the SFI and its subcontractors?	This question is not relevant to the development of a proposal under this RFP.

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1261	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	How will the Department ensure that the best practices outlined in Section 4.2 are uniformly implemented and adhered to by the SFI and its subcontractors, given the lack of corresponding statutory or regulatory mandates?	This question is not relevant to the development of a proposal under this RFP.
1262	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	Can the Department detail the rationale behind including these specific best practices in the RFP, and how they were determined to be essential for the effective delivery of CDPAP services?	This question is not relevant to the development of a proposal under this RFP.
1263	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	In the event that the best practices outlined in Section 4.2 conflict with existing operational practices of current fiscal intermediaries, how will the Department resolve such conflicts to ensure seamless service delivery and compliance?	This question is not relevant to the development of a proposal under this RFP.
1264	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	How does the Department intend to address potential legal challenges that may arise from imposing these best practices without clear statutory or regulatory authority?	This question is not relevant to the development of a proposal under this RFP.
1265	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	Will there be a system for consumers and PA's to report deviations from the best practices?	This question is not relevant to the development of a proposal under this RFP.
1266	Best Practices	Section 4.2: Best Practices, Paragraph 1 (Page 6 of RFP)	What methodologies has the Department of Health used to include feedback, input, and suggestions from consumers when constructing this RFP in order to effectively evaluate whether submitted proposals will "best meet the needs of consumers" as specified within this section?	This question is not relevant to the development of a proposal under this RFP.
1267	Best Practices	Section 4.2: Best Practices (Page 6 of RFP)	How does the Department plan to measure and evaluate the adherence to the best practices listed in Section 4.2, and what metrics will be used to assess their impact on service quality and consumer satisfaction?	This question is not relevant to the development of a proposal under this RFP.
1268	CDPAP Current Consumers	General	How many CDPAP members also qualify for the PCA program?	This question is not relevant to the development of a proposal under this RFP.
1269	Complaints	Section 4.2: Best Practices (Page 6 of RFP)	Who will be held responsible if questions/complaints are submitted through the website or email system are not promptly answered or resolved?	This question is not relevant to the development of a proposal under this RFP.
1270	Compliance	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	If the statewide Fiscal Intermediary (FI) does not have an effective compliance program, considering it is the only FI, will all the claims be at risk for recoupment for that period, as outlined in Section 4.4 of the RFP	This question is not relevant to the development of a proposal under this RFP.
1271	Compliance	Section 5.4: Payment (Page 12 of RFP)	The regulation governing notice and payment of CDPAP Medicaid fee-for-service rates, 18 NYCRR §505.14 Personal Care Service, Section (h) Payment, Subdivision (7), Part (iii) Revision of Rates, Paragraph (a), mandates that "The department will notify each provider of its approved rates of payments at least 30 days prior to the beginning of an established rate period for which the rate is to become effective." The Department has consistently failed to comply with this regulation, notifying Fiscal Intermediary providers of their approved reimbursement rates well beyond the required 30-day period. Existing Fiscal Intermediary entities have faced significant delays in notification and payment of their actual rates for more than a decade, causing cash flow issues and financial hardships exacerbated by the inherent two-year lag within the rate-setting methodology, where providers' reported costs for one year are used to establish rates two years later. For instance, the formal notice for the 2022 rates, effective from January 1, 2022, was only provided on May 9, 2023, a delay of 493 days. Historical data shows notification delays ranging from 32 to 493 calendar days for rates effective between 2017 and 2022. These prolonged timelines and delayed payments place an undue burden on providers, jeopardizing their financial stability and operational capacity. Given this track record, how does the Department plan to ensure compliance with the existing regulation that mandates timely notifications and payments of reimbursement rates? Specifically, what measures will be implemented to guarantee that the Statewide FI receives timely and accurate rate notifications to prevent financial disruptions and ensure regulatory compliance?	This question is not relevant to the development of a proposal under this RFP.

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1272	Compliance	Section 5.7: Subcontracting (Pages 15-16 of RFP)	If additional requirements and restrictions are implemented by the Department, will additional components of the Statewide FI's contract be opened for renegotiation to compensate for resultant changes to associated costs or administrative functions?	This question is not relevant to the development of a proposal under this RFP.
1273	Compliance	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	Page 7 of the RFP, section 4.4 "Statewide Fiscal Intermediary Compliance Requirements" states that the statewide FI must comply with all applicable State and federal laws, rules, regulations, and guidance. If a company has an outstanding OMIG report, why is that company not allowed to continue its business due to the parameters of the RFP?	This question is not relevant to the development of a proposal under this RFP.
1274	Compliance	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	What mechanisms will the Department implement to ensure that an out-of-state SFI, once enrolled as a New York State Medicaid provider, maintains ongoing compliance with all state-specific regulations and standards?	This question is not relevant to the development of a proposal under this RFP.
1275	Compliance	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	Why doesn't the list of restrictions relating to ownership suggesting a conflict of interest include that of a current privately owned Fiscal Intermediary?	This question is not relevant to the development of a proposal under this RFP.
1276	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	Why is there any suggestion that ownership or control of a fiscal intermediary by a LHCSA or vice versa could be a conflict of interest when Social Services Law section 365-f as originally enacted explicitly listed LHCSAs as entities eligible to be fiscal intermediaries, and LHSCAs continue to be authorized to own and operate fiscal intermediaries?	This question is not relevant to the development of a proposal under this RFP.
1277	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	Why is there any suggestion that ownership or control of a fiscal intermediary by a LHCSA or vice versa could be a conflict of interest when such a restriction was proposed and rejected by the Legislature?	This question is not relevant to the development of a proposal under this RFP.
1278	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP)	Ultimately, the final NYS budget rejected conflict language related to FI/LHCSA ownership and FI/LHCSA/MCO. Is the inclusion of the concept in the RFP binding?	This question is not relevant to the development of a proposal under this RFP.
1279	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	The RFP states that the awarded Statewide FI must "Ensure the avoidance of actual or perceived conflicts of interest while operating as the Statewide FI." This is further defined to include "An entity that is owned or controlled by a Licensed Home Care Services Agency (LHCSA) or a Managed Care Organization (MCO) in New York State or that owns or holds the controlling interest in a LHCSA or MCO in New York State." Under what legal authority does the Department determine that a FI operating a MLTC or LHCSA is a conflict of interest given that this provision was rejected by the Legislature as part of the SFY 2024-25 Budget?	This question is not relevant to the development of a proposal under this RFP.
1280	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP	Please elaborate on why the State deems it a conflict of interest to be the single statewide FI and also an entity that is owned or controlled by a Licensed Home Care Services Agency (LHCSA) or a Managed Care Organization (MCO) in New York State or that owns or holds the controlling interest in a LHCSA or MCO in New York State?	This question is not relevant to the development of a proposal under this RFP.
1281	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP	We understand that entities owned or controlled by a Licensed Home Care Services Agency (LHCSA) are mentioned as potentially having a conflict of interest in Section 4.5.d. Given our long-term track record of compliance with DOH audits, established caps on LHCSA expansion, and extensive history in providing home care, we believe LHCSAs bring significant benefits as a fiscal intermediary. Can you provide concrete examples of why a LHCSA as a fiscal intermediary is considered a conflict of interest?	This question is not relevant to the development of a proposal under this RFP.
1282	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet d) (Page 8 of RFP	What specific statutory or regulatory authority does the RFP rely on for the conflict of interest provisions for LHCSA's and MCOs?	This question is not relevant to the development of a proposal under this RFP.
1283	Conflict of Interest	Section 4.5: Fiscal Intermediary Organizational Requirements (Page 8 of RFP)	Under 4.5 d, what legal authority do you have to include this subsection? Especially when the legislature specifically rejected the same proposal in the 2024 legislative section.	This question is not relevant to the development of a proposal under this RFP.
1284	Consumer responsibilities	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet a) (Page 8 of RFP)	If the selected FI refuses to serve a Consumer, will the Consumer be entitled to a fair hearing?	This question is not relevant to the development of a proposal under this RFP.

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1285	Consumer responsibilities	Section 4.5: Fiscal Intermediary Organizational Requirements, Bullet a) (Page 8 of RFP)	If the selected FI terminates services to a Consumer, will the Consumer be entitled to a fair hearing?	This question is not relevant to the development of a proposal under this RFP.
1286	Consumer responsibilities	Section 4.1: Required Fiscal Intermediary Services, Bullet g) (Page 5 of RFP)	Will the consumer be able to contest/appeal the decision?	This question is not relevant to the development of a proposal under this RFP.
1287	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	The RFP provides for termination of the contract with the Statewide FI in limited circumstances. In the event that the Department of Health had to exercise its authority under this section and terminate the contract of the Statewide FI, what contingency plans are in place to ensure that the 250,000 consumers receive services?	This question is not relevant to the development of a proposal under this RFP.
1288	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	The RFP provides for termination of the contract with the Statewide FI in limited circumstances. In the event that the Department of Health had to exercise its authority under this section and terminate the contract of the Statewide FI, what contingency plans are in place to ensure that the approximately 350,000 consumer directed personal assistants continue to be paid for their work?	This question is not relevant to the development of a proposal under this RFP.
1289	Contracting	General	What is the justification or rationale for awarding a contract of this magnitude without the oversight of the New York State Comptroller and outside of the state's usual contracting process?	This question is not relevant to the development of a proposal under this RFP.
1290	Contracting	General	If the state does not receive any valid proposals for the statewide FI role, will the process start over, or the deadline be extended?	This question is not relevant to the development of a proposal under this RFP.
1291	Contracting	General	What is the role of the comptroller in the approval process?	This question is not relevant to the development of a proposal under this RFP.
1292	Contracting	General	What is the justification or rationale for awarding a contract of this magnitude without the oversight of the New York State Comptroller and outside of the state's usual contracting process?	This question is not relevant to the development of a proposal under this RFP.
1293	Contracting	Section 1.0: Calendar of Events (Page 3 of RFP)	Will alternate timelines for vendor startup and consumer transition be considered?	This question is not relevant to the development of a proposal under this RFP.
1294	Contracting	Section 1.0: Calendar of Events (Page 3 of RFP)	How can the bid become effective without comptrollers' office involvement?	This question is not relevant to the development of a proposal under this RFP.
1295	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	The RFP indicates that the five-year contract term commences on the date the contract is approved by the Commissioner of Health. Please confirm that there will be no Comptroller review and approval prior to the execution of the contract. What will the scope of the Comptroller's oversight be after implementation of the contract?	This question is not relevant to the development of a proposal under this RFP.
1296	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	Will an FI have any administrative appeal rights prior to contract suspension/termination/limitation of rights and privileges by the Department?	This question is not relevant to the development of a proposal under this RFP.
1297	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	The contract term is identified as five years. How was this time frame arrived at?	This question is not relevant to the development of a proposal under this RFP.
1298	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	To address concerns of the Disability Community that this contract is being developed to further reduce access to consumer directed home and community-based services, is there an amendment procedure for the Statewide FI contract if it is determined that their ability to fully execute the terms of the contract changes within the 5-year term?	This question is not relevant to the development of a proposal under this RFP.
1299	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	What is the appeal process for termination of the Statewide FI contract?	This question is not relevant to the development of a proposal under this RFP.
1300	Contracting	Section 2.3: Term of the Agreement and Termination Provisions (Page 4 of RFP)	How would the state proceed with finding another agency to replace the Statewide FI if their contract is terminated?	This question is not relevant to the development of a proposal under this RFP.

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1301	Contracting	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet a) (Pages 7-8 of RFP)	There is a significant backlog of Medicaid Provider Enrollments and an application takes months for the Department to process. If the expected contract award date is October 1, 2024 and FI applications are to be submitted by August 2, 2024, if a successful bidder is not enrolled as a Medicaid Provider, will the Department process the Medicaid Provider Enrollment Application in a timely manner to meet the October 1st deadline?	This question is not relevant to the development of a proposal under this RFP.
1302	Contracting	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	What is the timeline for enrolling the SFI as a Medicaid provider (if not currently enrolled)? What happens if the selected FI cannot meet the timeline?	This question is not relevant to the development of a proposal under this RFP.
1303	Contracting	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	Can the Department outline the specific process and estimated timeline for enrolling an SFI as a New York State Medicaid provider if they are not currently enrolled? What criteria and documentation will be required to determine and finalize the SFI's status as a Medicaid-enrolled provider?	This question is not relevant to the development of a proposal under this RFP.
1304	Contracting	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	In the event that an out-of-state SFI fails to meet the Medicaid enrollment criteria within the specified timeframe, what alternative plans does the Department have to ensure continuity of care and service delivery for consumers in New York State?	This question is not relevant to the development of a proposal under this RFP.
1305	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	How was the amount of $100,000,000 for the Line of Credit determined?	This question is not relevant to the development of a proposal under this RFP.
1306	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	How did the Department determine the required amount for the line of credit?	This question is not relevant to the development of a proposal under this RFP.
1307	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	What is the $100 million figure for a required line of credit based on?	This question is not relevant to the development of a proposal under this RFP.
1308	Credit	Section 5.6.2: Revolving Credit Facility (Pages 14-15 of RFP)	Why the $100 million line of credit? And what authority does NYSDOH have to impose a line of credit? How did you pick that number?	This question is not relevant to the development of a proposal under this RFP.
1309	Eligibility	Section 3.1: Minimum Qualifications (Page 4 of RFP)	Can the Department provide a rationale for the requirement that the minimum Statewide FI qualification, "as of April 1, 2024, is providing services as a fiscal intermediary on a statewide basis in at least one other state," effectively excludes entities performing statewide CDPAP fiscal intermediary services solely in New York State? If New York-based entities can demonstrate their ability to fulfill "fiscal intermediary service" requirements (as specified in the current statute, regulation, and RFP #20524) on a statewide basis within New York State, why are these entities excluded from qualifying as a Statewide FI simply because they do not operate in another state? Does this exclusion undermine the Equal Protection Law and contradict New York State's commitment to supporting and encouraging New York/local businesses, especially those already providing capable and comprehensive fiscal intermediary services statewide within New York?	This question is not relevant to the development of a proposal under this RFP.
1310	Eligibility	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	Section 3.1a) states in part that entities eligible to submit a bid include "[a]n entity … [that] as of April 1st, 2024, is providing services as a fiscal intermediary on a statewide basis in at least one other state." As written, this provision is unduly restrictive and illogical, having no rational correlation to an entity's ability to provide the services contemplated by the RFP. The provision precludes an entity from qualifying, even when the entity has been providing fiscal intermediary services in the state of New York for years, unless the entity also provides such services to another state. Accordingly, we request that the language be amended as follows: "an entity [that] as of April 1st 2024, was providing services as a fiscal intermediary IN NEW YORK or in at least one other state." If for any reason DOH actually intends to exclude New York fiscal intermediary experience from eligibility consideration, please state the reason why.	This question is not relevant to the development of a proposal under this RFP.
1311	Eligibility	Section 4.0: Scope of Work (Page 5 of RFP)	If an agency has a proven record of delivering services to individuals with disabilities, the senior population and to a diverse population, maintains a local presence in a widespread geographic area, and was awarded Lead Fiscal Intermediary status in the first round of the 2021 RFO, why should the agency be excluded from being awarded the state FI contract other than not being an FI prior to January 1, 2012?	This question is not relevant to the development of a proposal under this RFP.

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1312	Eligibility	Section 5.4: Payment (Page 12 of RFP)	Can providers other than the SFI act as the FI for Consumer Directed programs that are funded outside of Medicaid, such as those funded through EISEP?	This question is not relevant to the development of a proposal under this RFP.
1313	Eligibility	Section 8.1: General Information (Pages 25-26 of RFP)	If a bidder is deemed ineligible for award as the Statewide FI due to insufficient ability to meet the requirements specified within this RFP, how will they be notified? Will non-awardees be provided with details regarding the exact nature of their ineligibility, including specific criteria they failed to meet?	This question is not relevant to the development of a proposal under this RFP.
1314	Eligibility	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	Who has the Department identified as likely bidders?	This question is not relevant to the development of a proposal under this RFP.
1315	Evaluation	Section 3.1: Minimum Qualifications, Bullet a) (Page 4 of RFP)	How will the Department determine whether a bidder performed statewide FI services in another state?	This question is not relevant to the development of a proposal under this RFP.
1316	Evaluation	Section 8.6: Best and Final Offers (Page 26 of RFP)	Will Bidders who are requested to provide a Best and Final Offer be informed of current cost proposal bids or the lowest bid?	This question is not relevant to the development of a proposal under this RFP.
1317	Evaluation	Section 8.6: Best and Final Offers (Page 26 of RFP)	Please define “proposal that are susceptible to award”.	This question is not relevant to the development of a proposal under this RFP.
1318	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	Can the Department provide specific examples or case studies where the "Best Value" concept has been successfully applied in similar contexts to ensure clarity on its practical application?	This question is not relevant to the development of a proposal under this RFP.
1319	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	The statute allows for a competitive bidding process that oversteps typical state procurement laws. How will the Department ensure transparency and fairness in the selection process of the Statewide Fiscal Intermediary, given the "Notwithstanding" clause in the state finance law? What safeguards are in place to prevent conflicts of interest and ensure the best value for consumers and the state?	This question is not relevant to the development of a proposal under this RFP.
1320	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	Given the confidentiality of the evaluation process, how will the Department of Health ensure transparency and fairness in the scoring and selection of the winning proposal?	This question is not relevant to the development of a proposal under this RFP.
1321	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	Under Section 8.1, what does DOH mean by an evaluation process conducted in a “comprehensive and impartial manner”? What, if any, guidelines or oversight will DOH implement to ensure that the “evaluation process will be conducted in a comprehensive and impartial manner”?	This question is not relevant to the development of a proposal under this RFP.
1322	Evaluation	Section 8.1: General Information (Pages 25-26 of RFP)	Can the Department of Health explain the reasoning behind weighing the Cost Proposal at 35% of the proposal’s total score? How is the State planning to ensure that the “Best Value” concept described in Section 8.1 doesn’t encourage Cost Proposal bids that undercut a Fiscal Intermediaries’ ability to provide quality services with as little disruption to consumers and PAs as possible?	This question is not relevant to the development of a proposal under this RFP.
1323	Evaluation	Section 8.3: Technical Evaluation (Page 26 of RFP)	Has the Department prepared a scoring methodology?	This question is not relevant to the development of a proposal under this RFP.
1324	EVV	General	Does NYS intend to create policies to assist with EVV Compliance?	This question is not relevant to the development of a proposal under this RFP.
1325	EVV	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet i) (Pages 7-8 of RFP)	Not all Consumers or PAs comply with EVV requirements. How will the selected bidder be measured for EVV compliance?	This question is not relevant to the development of a proposal under this RFP.
1326	EVV	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet h) (Page 9 of RFP)	What information should be included in the quarterly report, and what format should the report be in?	This question is not relevant to the development of a proposal under this RFP.
1327	EVV	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet h) (Page 9 of RFP)	Will the quarterly EVV compliance report be made available to the public?	This question is not relevant to the development of a proposal under this RFP.

New York State Department of Health
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Number	Subject	Corresponding RFP Section	Question	Answer
1328	EVV	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet h) (Page 9 of RFP)	What information should be included in the quarterly report, and what format should the report be in?	This question is not relevant to the development of a proposal under this RFP.
1329	EVV	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet h) (Page 9 of RFP)	RFP Section 4.6: h) Provide the Department with a quarterly report regarding the Contractor's EVV compliance with section 12006(a) of the 21st Century Cures Act and the bidder's EVV system's completeness and accuracy as required by 18 NYCRR Part 514. What is the minimum percentage of successful EVV compliance on a weekly or monthly basis? If a PA forgets to clock in/out, the successful percentage can decrease; therefore, understanding the minimum percentage expectation is important. If using GPS to capture the location of service, what is the acceptable feet/distance from the consumer's location?	This question is not relevant to the development of a proposal under this RFP.
1330	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet a) (Page 9 of RFP)	Will the annual cost report information be available to the public?	This question is not relevant to the development of a proposal under this RFP.
1331	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet a) (Page 9 of RFP)	Will the public have an opportunity to comment on the annual cost reports?	This question is not relevant to the development of a proposal under this RFP.
1332	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet b) (Page 9 of RFP)	Will the written fiscal procedures be published or made available to the public to review?	This question is not relevant to the development of a proposal under this RFP.
1333	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet d) (Page 9 of RFP)	How can a statewide FI contractor objectively oversee and investigate itself for fiscal integrity?	This question is not relevant to the development of a proposal under this RFP.
1334	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet a) (Page 9 of RFP)	What safeguards will the Department implement to ensure that the single statewide FI does not prioritize cost-cutting over service quality, potentially leading to reduced wages and benefits for personal assistants and lower standards of care for consumers?	This question is not relevant to the development of a proposal under this RFP.
1335	Fiscal Oversight	Section 4.6: Fiscal Monitoring and Oversight Requirements, Bullet a) (Page 9 of RFP)	Will cost reports continue to be processed through DOH/KPMG?	This question is not relevant to the development of a proposal under this RFP.
1336	Fraud	General	In what ways does this RFP further the goal of curbing fraud, waste, and abuse when there already exists appropriate investigative authority in the New York State Office of Medicaid Inspector General and Medicaid Fraud Control Unit?	This question is not relevant to the development of a proposal under this RFP.
1337	Fraud	Section 4.6: Fiscal Monitoring and Oversight Requirements (Page 9 of RFP)	Recent accusations of widespread fraud within CDPAP have cast a shadow over the program. What specific information or data, relevant to other in-state and out-of-state programs, can the Department provide to support CDPAP has more fraudulent activity in relation to program-population size?	This question is not relevant to the development of a proposal under this RFP.
1338	Health Assessment	Section 4.1: Required Fiscal Intermediary Services, Bullet d) (Page 5 of RFP)	Will the fiscal intermediary need to perform health assessments of each PA prior to service delivery?	This question is not relevant to the development of a proposal under this RFP.
1339	Joint Employer	Section 4.2: Best Practices, Bullet b), c), and d) (Page 6 of RFP)	Why is it a better practice to visit a consumer's home, conduct orientation for PAs, or engage in activities such as the supporting of recruiting and terminating PAs, if it is not the responsibility of the statewide FI to provide these or any personal care services as per RPF section 4.1 Required Fiscal Intermediary Services?	This question is not relevant to the development of a proposal under this RFP.
1340	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Considering the anticipated joint employer status of the Statewide FI and the consolidation of numerous existing FI entities into a single Statewide FI, how does the Department plan to accurately project the overall costs and anticipated savings, including potential increases in direct care expenses and liabilities associated with the joint employer status?	This question is not relevant to the development of a proposal under this RFP.

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Number	Subject	Corresponding RFP Section	Question	Answer
1341	Joint Employer	Section 4.3: Fiscal Intermediary Employment Related Responsibilities and Joint Employment Requirements (Pages 6-7 of RFP)	Why has the State and/or Department not included the specific joint employer language in the statute or regulation?	This question is not relevant to the development of a proposal under this RFP.
1342	Marketing	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet j) (Pages 7-8 of RFP)	Will the Department guidance, etc. regarding marketing and marketing materials conform to state and federal constitutional standards regarding the limitations of speech?	This question is not relevant to the development of a proposal under this RFP.
1343	Marketing	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet j) (Pages 7-8 of RFP)	Will subcontractors be subject to DOH guidance regarding marketing of FI services	Department projections will not be provided. Bidders should review historic and publicly available information to inform their own assumptions.
1344	Marketing	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet j) (Pages 7-8 of RFP)	Will DOH guidance concerning marketing be made available to the public?	This question is not relevant to the development of a proposal under this RFP.
1345	Marketing	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet j) (Pages 7-8 of RFP)	Will the Department commit that it will not issue guidance, etc. regarding marketing and marketing materials that intentionally violate state and federal standards regarding the limitations of speech?	This question is not relevant to the development of a proposal under this RFP.
1346	Marketing	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	In 4.4(j), the Statewide FI is identified as being responsible for complying with "Department issued guidance and directives, and any other guidance, templates or directives the Department may issue with respect to marketing and marketing materials." What guidance and directives currently exist in relation to marketing and marketing materials?	This question is not relevant to the development of a proposal under this RFP.
1347	MCO Contracting	Section 4.0: Scope of Work, Third Bullet (Page 5 of RFP)	MLTC's were not effective until after 2013. How can any FI have a contract with an MLTC for Consumer Directed Services as of January 1, 2012 or earlier if MLTC's did not provide this service until after 2012.	This question is not relevant to the development of a proposal under this RFP.
1348	MCO Contracting	Section 4.1: Required Fiscal Intermediary Services, Bullet h) (Page 5 of RFP)	Will DOH annually review the contracts the Single FI must enter into with the MCO's?	This question is not relevant to the development of a proposal under this RFP.
1349	Monopoly	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	Consolidating fiscal intermediaries into a single entity raises significant concerns regarding monopoly, legal protections, and accountability in CDPAP. Has the Department evaluated these risks, and what safeguards will be implemented to protect consumers from potential abuses of power?	This question is not relevant to the development of a proposal under this RFP.
1350	Monopoly	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	How does the Department plan to maintain accountability and innovation in service delivery if competition among fiscal intermediaries is eliminated, potentially leading to stagnation in service quality and efficiency?	This question is not relevant to the development of a proposal under this RFP.
1351	Monopoly	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	What specific analyses and data does the Department have to support the assertion that a single fiscal intermediary will not exploit its position to lobby for regulations that serve its interests or cut corners in service provision, potentially harming consumers and personal assistant workers?	This question is not relevant to the development of a proposal under this RFP.
1352	Monopoly	Section 4.7: Quality Monitoring and Reporting Requirements (Page 9 of RFP)	How will the Department monitor and enforce quality standards for the single statewide FI to ensure that the level of service remains consistent with the current multi-FI model?	Bidders should review historic and publicly available information to inform their own assumptions.
1353	Monopoly	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	What measures will be put in place to prevent potential monopolistic practices and ensure fair competition among subcontractors in the single statewide FI model?	This question is not relevant to the development of a proposal under this RFP.

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Number	Subject	Corresponding RFP Section	Question	Answer
1354	MWBE	Section 5.5: Minority & Women-Owned Business Enterprise (M/WBE) Requirements and Equal Employment Opportunity (EEO) Reporting (Page 13 of RFP)	The MWBE Requirement for this opportunity has been identified as 0%. Why has the Department determined that this contract is not subject to the terms of the MWBE policy for contracting and subcontracting?	This question is not relevant to the development of a proposal under this RFP.
1355	No Subcontractors	Section 4.0: Scope of Work (Page 5 of RFP)	What happens if the selected FI does not contract with one or more independent living centers?	This question is not relevant to the development of a proposal under this RFP.
1356	No Subcontractors	Section 4.0: Scope of Work (Page 5 of RFP)	What happens if the selected FI does not contract with at least one entity per NYS DOH MLTC rate setting region that has a proven record of delivering services to individuals with disabilities and the senior population and has been providing fiscal intermediary services since January 1, 2012, or earlier?	This question is not relevant to the development of a proposal under this RFP.
1357	Overtime	General	With the single FI, Overtime will skyrocket. Is the state going to create regulations to set the rules regarding it?	This question is not relevant to the development of a proposal under this RFP.
1358	Overtime	Section 4.1: Required Fiscal Intermediary Services, Bullet b) (Page 5 of RFP)	As scheduling is the responsibility of the consumer, how will the usage of overtime be handled?	This question is not relevant to the development of a proposal under this RFP.
1359	Overtime	Section 4.1: Required Fiscal Intermediary Services, Bullet a) (Page 5 of RFP)	Will the consumer need to get permission to use overtime?	This question is not relevant to the development of a proposal under this RFP.
1360	Overtime	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements (Pages 7-8 of RFP)	If the Statewide FI cannot limit the amount of overtime a Consumer can schedule, how will the Department ensure that rates are sufficient to pay the required overtime?	This question is not relevant to the development of a proposal under this RFP.
1361	Overtime	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet f) (Pages 7-8 of RFP)	Will Plans be required to compensate the selected FI for PA overtime?	This question is not relevant to the development of a proposal under this RFP.
1362	Overtime	Section 4.4: Statewide Fiscal Intermediary Compliance Requirements, Bullet e) (Pages 7-8 of RFP)	If overtime is allowed, who is responsible for funding the overtime pay when the consumer schedules their PAs' overtime? Will overtime pay be reimbursed to the statewide fiscal intermediary?	This question is not relevant to the development of a proposal under this RFP.

APPENDIX 4

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

SMDL #01-006

Olmstead Update No: 4
Subject: HCFA Update
Date: January 10, 2001

Dear State Medicaid Director:

This is the fourth in a series of letters designed to provide guidance and support to States in their efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs, consistent with the Americans with Disabilities Act (ADA). In attachments to this letter, we address certain issues related to allowable limits in home and community-based services (HCBS) waivers under section 1915(c) of the Social Security Act.

In attachments to this letter, we address certain questions related to State discretion in the design and operation of HCBS waivers under section 1915(c) of the Social Security Act. We also explain some of the principles and considerations that the Health Care Financing Administration (HCFA) will apply in the review of waiver requests and waiver amendments. Finally, we respond to key questions that have arisen in the course of State or constituency deliberations to improve the adequacy and availability of home and community-based services, or recent court decisions.

We encourage you to continue forwarding your policy-related questions and recommendations to the ADA/Olmstead workgroup through e-mail at ADA/Olmstead@hcfa.gov.

HCFA documents relevant to Medicaid and the ADA are posted on the ADA/Olmstead website at **http://www.hcfa.gov/medicaid/olmstead/olmshome.htm**.

Sincerely,

Timothy M. Westmoreland
Director

Enclosures

Attachment 4-A "Allowable Limits and State Options in HCBS waivers"

State Medicaid Director – 2

cc:
HCFA Regional Administrators

HCFA Associate Regional Administrators for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
National Association of State Medicaid Directors

Joy Wilson
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Virginia Dize
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Attachment 4-A
Subject: Allowable Limits and State Options in HCBS Waivers
Date: January 10, 2001

In this attachment, we discuss limits that States may place on the number of persons served and on services provided under an HCBS waiver. Current law requires States to identify the total number of people who may be served in an HCBS waiver in any year. States may derive this overall enrollment limit from the amount of funding the legislature has appropriated. However, once individuals are enrolled in the waiver, the State may not cap or limit the number of enrolled waiver participants who may receive a covered waiver service that has been found necessary by an assessment.

We have received a number of questions regarding limits that States may, or are required to, establish in HCBS waivers under section 1915(c) of the Social Security Act. Many of these questions have arisen in the course of discussions about the ADA and the Supreme Court Olmstead decision. Others have arisen in the context of certain court cases premised on Medicaid law. Examples include:

1. ***Overall Number of Participants:*** May a State establish a limit on the total number of people who may receive services under an HCBS waiver?

2. ***Fiscal Appropriation:*** May a State use the program's funding appropriation to specify the total number of people eligible for an HCBS waiver?

3. ***Access to Services Within a Waiver***: May a State have different service packages within a waiver? Once a person is enrolled in an HCBS waiver, can the individual be denied a needed service that is covered by the waiver based on a State limit on the number of enrollees permitted access to different waiver services?

4. ***Sufficiency of Amount, Duration, and Scope of Service****s*: What principles will HCFA apply in reviewing limitations that States maintain with respect to waiver services?

5. ***Amendments that Lower the Potential Number of Participants*****:** May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?

6. ***Establishing Targeting Criteria for Waivers:*** How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?

In subjects 1 and 2, we explain current law and policy regarding the setting of limits on the total number of people who may be eligible for an HCBS waiver. In subject 3, we provide new clarification with respect to the access that waiver enrollees must be afforded within a waiver, consistent with recent court decisions. In subject 4, we explain that, while section 1915(c) permits a waiver of many Medicaid requirements, the requirement for adequate amount, duration, and scope is not waived. In subject 5, we discuss special considerations that HCFA will apply when reviewing any waiver amendment request in which the total number of eligible individuals would be reduced, so that the implications of the proposed amendment are fully addressed in light of all applicable legal considerations. In subject 6, we seek to reduce State administrative expenses by permitting States to develop a single waiver for people who have a disability or set of conditions that cross over more than one current waiver category.

The answers to the questions below are derived from Medicaid law. However, because Medicaid HCBS waivers affect the ability of States to use Medicaid to fulfill their obligations under the ADA and other statues, we have included these answers as an Olmstead/ADA update.

1. Overall Number of Participants

> *May a State establish a limit on the total number of people who may receive services under an HCBS waiver?*

Yes. Under 42 CFR 441.303(f)(6), States are required to specify the number of unduplicated recipients to be served under HCBS waivers:

> The State must indicate the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program. This number will constitute a limit on the size of the waiver program unless the State requests and the Secretary approves a greater number of waiver participants in a waiver amendment.

Thus, unlike Medicaid State plan services, the waiver provides an assurance of service only within the limits on the size of the program established by the State and approved by the Secretary. The State does not have an obligation under Medicaid law to serve more people in the HCBS waiver than the number requested by the State and approved by the Secretary. If other laws (e.g., ADA) require the State to serve more people, the State may do so using non-Medicaid funds or may request an increase in the number of people permitted under the HCBS waiver. Whether the State chooses to avail itself of possible Federal funding is a matter of the State's discretion. Failure to seek or secure Federal Medicaid funding does not generally relieve the State of an obligation that might be derived from other legislative sources (beyond Medicaid), such as the ADA.

If a State finds that it is likely to exceed the number of approved participants, it may request a waiver

amendment at any time during the waiver year. Waiver amendments may be retroactive to the first day of the waiver year in which the request was submitted.

2. Fiscal Appropriation

May a State use the program's funding appropriation to specify the total number of people eligible for an HCBS waiver?

HCFA has allowed States to indicate that the total number of people to be served may be the lesser of either (a) a specific number pre-determined by the State and approved by HCFA (the approved "factor C" value), or (b) a number derived from the amount of money the legislature has made available (together with corresponding Federal match). The current HCBS waiver pre-print used by States to apply for waivers contains both options. States sometimes use the second option because of the need to seek Federal waiver approval prior to the appropriation process, and sometimes the legislative appropriations are less than the amount originally anticipated. In addition, the rate of turnover and the average cost per enrollee may turn out to be different than planned, thereby affecting the total number of people who may be served.

In establishing the maximum number of persons to be served in the waiver, the State may furnish, as part of a waiver application, a schedule by which the number of persons served will be accepted into the waiver. The Medicaid agency must inform HCFA in writing of any limit that is subsequently derived from a fiscal appropriation, and supply the calculations by which the number or limit on the number of persons to be served was determined. This information will be considered a notification to HCFA rather than a formal amendment to the waiver if it does not substantially change the character of the approved waiver program. If a State fails to report this limit, HCFA will expect the State to serve the number of unduplicated recipients specified in the approved waiver estimates.

3. Access to Services Within a Waiver

May a State have different service packages within a waiver? Once a person is enrolled in a HCBS waiver, can the individual be denied a needed service that is covered by the waiver based on a State limit on the number of enrollees permitted access to different waiver services?

No. A State is obliged to provide all people enrolled in the waiver with the opportunity for access to all needed services covered by the waiver and the Medicaid State plan. Thus, the State cannot develop separate and distinct service packages for waiver population subgroups within a single waiver. The opportunity for access pertains to all services available under the waiver that an enrollee is determined to need on the basis of an assessment and a written plan of care/support.

This does not mean that all waiver participants are entitled to receive all services that theoretically could be available under the waiver. The State may impose reasonable and appropriate limits or utilization

control procedures based on the need that individuals have for services covered under the waiver. An individual's right to receive a service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria that the State develops and applies fairly to all waiver enrollees.

This clarification does mean, however, that States are not allowed to place a cap on the number of enrollees who may receive a particular service within the waiver. There is no authority provided under law or regulation for States to impose a cap on the number of people who may use a waiver service that is lower than the total number of people permitted in the waiver. Denial of a needed and covered service within a waiver would have the practical effect of: (a) undermining an assessment of need, (b) countermanding a plan of care/support based on such an assessment of need, (c) converting a feasible service into one that arbitrarily benefits some waiver participants but not others who may have an equal or greater need, and (d) jeopardizing an individual's health or welfare in some cases.

Similarly, a State may not limit access to a covered waiver service simply because the spending for such a service category is more than the amount anticipated in the budget. In the same way that nursing facilities may not deny nursing or laundry services to a resident simply because the nursing or laundry expenses for the year have exceeded projections, the HCBS waiver cannot limit access to services within the waiver based on the budget for a specific waiver-covered service. It is only the overall budget amount for the waiver that may be used to derive the total number of people the State will serve in the waiver. Once in the waiver, an enrolled individual enjoys protection against arbitrary acts or inappropriate restrictions, and the State assumes an obligation to assure the individual's health and welfare.

We appreciate that a State's ability to provide timely access to particular services within the waiver may be constrained by supply of providers, or similar factors. Therefore, the promptness with which a State must provide a needed and covered waiver service must be governed by a test of reasonableness. The urgency of an individual's need, the health and welfare concerns of the individual, the nature of the services required, the potential need to increase the supply of providers, the availability of similar or alternative services, and similar variables merit consideration in such a test of reasonableness. The complexity of "reasonable promptness" issues may be particularly evident when a change of living arrangement is required. Where the need for such a change is very urgent (e.g., as in the case of abuse in a person's current living arrangement), then "reasonable promptness" could mean "immediate." Where the need for a change of living arrangement for a particular person is clear but not urgent, application of the reasonableness test to determine "reasonable promptness" could provide more time.

We recognize the question of reasonable promptness is a difficult one. We wish to call the issue to your attention as a matter of considerable importance that merits your immediate review. The issue will receive more attention from us in the future and is already receiving attention by the courts. The essential message is that the State's ability to deliver on what it has promised is very important. During CY 2001, we expect to work closely with States to improve our common understanding of what reasonable promptness requires. We also hope to collaborate with you on the infrastructure

improvements that States may need to improve local ability to provide quality, customer-responsive and adequate services or supports in a timely manner.

4. Sufficiency of Amount, Duration and Scope of Services

What principles will HCFA apply in reviewing limitations that States maintain with respect to waiver services?

Federal regulations at 42 CFR 440.230(b) require that each Medicaid service must be sufficient in amount, duration, and scope to achieve the purpose of the service category. Within this broad requirement, States have the authority to establish reasonable and appropriate limits on the amount, duration and scope of each service.

In exercising discretion to approve new waiver requests, we will apply the same sufficiency concept to the entire waiver itself, i.e., whether the amount, duration and scope of all the services offered through the waiver (together with the State's Medicaid plan and other services available to waiver enrollees) is sufficient to achieve the purpose of the waiver to serve as a community alternative to institutionalization and assure the health and welfare of the individuals who enroll.

In applying this principle, it is not our intent to imply or establish minimum standards for the number or type of services that must be in an HCBS waiver. Because the waiver wraps around Medicaid State plan services, and because the needs of each target group vary considerably, it is clear that the sufficiency question may only be answered by a three-way review of (a) the needs of the selected target group, (b) the services available to that target group under the Medicaid State plan and other relevant entitlement programs, and (c) the type and extent of HCBS waiver services. Whether the combination of these factors would permit the waiver to meet its purpose, particularly its statutory purpose to serve as a community alternative to institutionalization, is an analysis we would expect each State to conduct.

Where a waiver design is manifestly incapable of serving as such an alternative for a preponderance of the State's selected target group, we would expect the State to make the adjustments necessary to remedy the problem in its waiver application for any new waiver. In other cases, an exceptionally limited service design may prevent an existing waiver from being able to assure the health or welfare of the individuals enrolled. Where, subsequent to a HCFA review of quality in an existing waiver, it is very clear that the waiver design renders it manifestly incapable of responding effectively to serious threats to the health or welfare of waiver enrollees, we would expect the State to make the necessary design adjustments to enable the State to fulfill its assurance to protect health and welfare. The fact that States have the authority to limit the total number of people who may enroll in a waiver provides States with reasonable methods to control the overall spending. This means that States should be able to manage their waiver budgets without undermining the waiver purpose or quality by exceptional restrictions applied to services that will be available within the waiver.

5. Amendments That Lower the Potential Number of Participants

May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?

A State may amend an approved waiver to lower the number of potential eligibles, subject to certain limitations. The following represent special considerations that HCFA will take into account in reviewing such waiver amendments:

Existing Court Cases or Civil Rights Complaints: If the number of waiver eligibles is a material item to any ongoing legal proceeding, investigation, finding, settlement, or similar circumstance, we will expect the State to (a) notify HCFA and the court of the State's request for a waiver amendment, and (b) notify HCFA and the DHHS Office for Civil Rights whenever a waiver amendment is relevant to the investigation or resolution of any pending civil rights complaint of which the State is aware.

***Avoiding or Minimizing Adverse Effects on Current Participants*:** Under section 1915(c)(2)(A), HCFA is required to assure that the State has safeguards to protect the health and welfare of individuals provided services under a waiver. Thus, a key consideration in HCFA's review of requests to lower the number of unduplicated recipients for an existing waiver is the potential impact on the current waiver population. By "current waiver population," we refer to people who have been found eligible and have enrolled in the waiver. Any reduction in the number of potential waiver eligibles must be accomplished in a manner that continues to assure the health, welfare, and rights of all individuals already enrolled in the waiver. An important consideration is whether a proposed reduction in waiver services would adversely affect the rights of current waiver enrollees to receive services in the most integrated setting appropriate, consistent with the ADA. The State may address these concerns in several ways:

- The State may provide an assurance that, if the waiver request is approved, the State will have sufficient service capacity to serve at least the number of current participants enrolled in the waiver as of the effective date of the amendment.

- The State may assure HCFA that no individuals currently served on the waiver will be removed from the program or institutionalized inappropriately due to the amendment. For example, the State may achieve a reduction through natural attrition.

- The State may provide an assurance and methodology demonstrating how individuals currently served by the waiver will not be adversely affected by the proposed amendment. For example, a State that no longer requires its waiver, because it has added as a State plan

service the principal service(s) provided by the waiver, may specify a method of transitioning waiver participants to the State plan service. We note that any individual who is subject to removal from a waiver is entitled to a fair hearing under Medicaid law, and the methodology of transition is particularly important in that context.

- The State may provide a plan whereby affected individuals will transition to other HCBS waivers without loss of Medicaid eligibility or significant loss of services. We anticipate that this may occur when a State seeks to consolidate two or more smaller waivers into one larger program.

This discussion should not be construed as limiting a State's responsibilities to provide services to qualified individuals with disabilities in the most integrated settings appropriate to their needs as required by the ADA or other Federal or State law.

6. Establishing Targeting Criteria for Waivers

How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?

Under 42 CFR 441.301(b)(6), HCBS waivers must "be limited to one of the following targeted groups or any subgroup thereof that the State may define: (i) aged or disabled or both, (ii) mentally retarded or developmentally disabled or both, (iii) mentally ill." States have flexibility in establishing targeting criteria consistent with this regulation. States may define these criteria in terms of age, nature or degree or type of disability, or other reasonable and definable characteristics that sufficiently distinguish the target group in understandable terms.

HCFA recognizes that discrete target groups may encompass more than one of the categories of individuals defined in this regulation. For example, persons with acquired brain injury may be categorized as either physically disabled in accordance with section 441.301(b)(6)(i) or developmentally disabled in accordance with section 441.301(b)(6)(ii) depending on the age of the person when the brain injury occurred. In such cases, HCFA will permit the State to have one waiver to serve the defined target population that could conceivably encompass more than one category of the regulations in order to avoid the unnecessary administrative expense resulting from the development of a second waiver for the target population.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.

Attachment 4-B
Subject: EPSDT and HCBS Waivers
Date: January 10, 2001

In this attachment, we clarify ways in which Medicaid HCBS waivers and the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services interact to ensure that children receive the full complement of services they may need.

States may take advantage of Medicaid HCBS waivers under section 1915(c) of the Social Security Act to supplement the services otherwise available to children under Medicaid, or to provide services to children who otherwise would not be eligible for Medicaid. In both cases, States must ensure that (1) all children, including the children made eligible for Medicaid through their enrollment in a HCBS waiver, receive the EPSDT services they need, and (2) children receive all medically necessary Medicaid coverable services available under EPSDT. Because the HCBS waiver can provide services not otherwise covered under Medicaid, and can also be used to expand coverage to children with special health care needs, EPSDT and HCBS waivers can work well in tandem. However, a child's enrollment in an HCBS waiver cannot be used to deny, delay, or limit access to medically necessary services that are required to be available to all Medicaid-eligible children under federal EPSDT rules.

Under EPSDT requirements, generally children under age 21 who are served under the Medicaid program should have access to a broad array of services. State Medicaid programs must make EPSDT services promptly available [for any individual who is under age 21 and who is eligible for Medicaid] whether or not that individual is receiving services under an approved HCBS waiver.

Included in the Social Security Act at section 1905(r), EPSDT services are designed to serve a twofold purpose. First, they serve as Medicaid's well-child program, providing regular screenings, immunizations and primary care services. The goal is to assure that all children receive preventive care so that health problems are diagnosed as early as possible, before the problems become complex and treatment more difficult and costly. Under federal EPSDT rules, States must provide for periodic medical, vision, hearing and dental screens. An EPSDT medical screen must include a comprehensive health and developmental history, including a physical and mental health assessment; a comprehensive unclothed physical examination; appropriate immunizations; laboratory tests, including lead blood level assessments appropriate for age and risk factors; and health education, including anticipatory guidance.

The second purpose of EPSDT services is to ensure that children receive the services they need to treat identified health problems. When a periodic or inter-periodic screening reveals the existence of a problem, EPSDT requires that Medicaid-eligible children receive coverage of all services necessary to

diagnose, treat, or ameliorate defects identified by an EPSDT screen, as long as the service is within the scope of section 1905(a) of the Social Security Act. (Please note that we have long considered any encounter with a health care professional practicing within the scope of his/her practice inter-periodic screening.) That is, under EPSDT requirements, a State must cover any medically necessary services that could be part of the basic Medicaid benefit if the State elected the broadest benefits permitted under federal law (not including HCBS services, which are not a basic Medicaid benefit). Therefore, EPSDT must include access to case management, home health, and personal care services to the extent coverable under federal law

Medicaid's HCBS waiver program serves as the statutory alternative to institutional care. This program allows States to provide home or community-based services (other than room and board) as an alternative to Medicaid-funded long term care in a nursing facility, intermediate care facility for the mentally retarded, or hospital.

- Under an HCBS waiver, States may provide services that are not otherwise available under the Medicaid statute. These may include homemaker, habilitation, and other services approved by HCFA that are cost-effective and necessary to prevent institutionalization. Waivers also may provide services designed to assist individuals to live and participate in their communities, such as prevocational and supported employment services and supported living services. HCBS waivers may also be used to provide respite care (either at home or in an out-of-home setting) to allow family members some relief from the strain of caregiving.

- In addition, under a Medicaid HCBS waiver, a State may provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income of a spouse or parent. This is accomplished through a waiver of section 1902(a)(10)(C)(i)(III) of the Social Security Act, regarding income and resource rules.

In all instances, HCBS waivers supplement but do not supplant a State's obligation to provide EPSDT services. A child who is enrolled in an HCBS waiver also must be assured EPSDT screening and treatment services. The waiver is used to provide services that are in addition to those available through EPSDT.

There are a number of distinctions between EPSDT services and HCBS waivers. While States may limit the number of participants under an HCBS waiver, they may *not* limit the number of eligible children who may receive EPSDT services. Thus, children cannot be put on waiting lists for Medicaid-coverable EPSDT services. While States may limit the services provided under an HCBS waiver in the ways discussed in attachment 4-A, States may *not* limit medically necessary services needed by a child who is eligible for EPSDT that otherwise could be covered under Medicaid. Children who are enrolled in the HCBS waiver must also be afforded access to the full panoply of EPSDT services. Moreover, under EPSDT, there is an explicit obligation to "make available a variety of individual and group providers qualified and willing to provide EPSDT services" 42 CFR 441.61(b).

Similarly, a State may use an HCBS waiver to extend Medicaid eligibility to children who otherwise would be eligible for Medicaid only if they were institutionalized. Such children are also entitled to the full complement of EPSDT services. Children made eligible for Medicaid through their enrollment in an HCBS waiver cannot be limited to the receipt of waiver services alone.

The combination of EPSDT and HCBS waiver services can allow children with special health care, as well as developmental and behavioral needs, to remain in their own homes and communities and receive the supports and services they need. The child and family can benefit most when the State coordinates its Medicaid benefits with special education programs in such a way as to enable the family to experience one system centered around the needs of the child. In developing systems to address the needs of children with disabilities, we encourage you to involve parents and other family members as full partners in your planning and oversight activities. HCFA staff will be pleased to consult with States that are working to structure children's programs around the particular needs of children with disabilities and their families.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.

APPENDIX 5

Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

June, 2012

v1.0

Table of Contents

Application for Section 1915(b) (4) Waiver
Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The **State** of Washington requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver programs** are:

- 1915(k) Community First Choice State Plan Option
- Optional State Plan personal care services
- 1915(c) New Freedom Waiver
- 1915 (c) Individual and Family Services (IFS) Waiver
- 1915(c) Basic Plus Waiver
- 1915(c) Children's Intensive In Home Behavior Support (CIIBS) Waiver
- 1915(c) Core Waiver

(List each program name if the waiver authorizes more than one program.).

Type of request. This is:
_X__ an initial request for new waiver. All sections are filled.
___ a request to amend an existing waiver, which modifies Section/Part ____
___ a renewal request
Section A is:
___ replaced in full
___ carried over with no changes
___ changes noted in **BOLD**.
Section B is:
___ replaced in full
___ changes noted in **BOLD**.

Effective Dates: This waiver is requested for a period of 5 years beginning 10/1/2021 and ending 9/30/2026.

State Contact: The State contact person for this waiver is Jamie Tong and can be reached by telephone at (360)725-3293, or fax at (360) 438-8633, or e-mail at jamie.tong@dshs.wa.gov. (List for each program)

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

The department has been committed to an inclusive and transparent effort regarding the development of the Consumer Directed Employer (CDE) program by engaging tribal governments throughout the process. A Dear Tribal Leader Letter was mailed on April 3, 2018 requesting a CDE project representative for the CDE strategic development group, and on August 3, 2018 notifying tribal partners of the intent by the department to issue a Request for Proposals (RFP) for a CDE. In addition, CDE developments were presented and consultation occurred at the following Tribal events:

April 10, 2018	Indian Policy Advisory Committee (IPAC) subcommittee meeting.
July 10, 2018	IPAC subcommittee meeting – Consumer Directed Employment Report
July 11, 2018	IPAC Quarterly Meeting
August 15, 2018	Tribal Roundtable #1
September 4, 2018	Tribal Roundtable #2
September 11, 2018	Tribal Consultation and Roundtable
November 1 and 2, 2018	Tribal Summit
November 8, 2018	Governor's Indian Health Council Meeting
December 4, 2018:	CDE Stakeholder and Tribal Engagement Report released
January 9, 2019	IPAC Quarterly Meeting
March 12, 2019	IPAC Subcommittee
April 9, 2019	IPAC Subcommittee
April 10, 2019	IPAC Quarterly Meeting
June 6, 2019	Tribal Summit

November 1, 2019	Tribal Summit
February 11, 2020	Consultation
June 9, 2020	IPAC Subcommittee
August 11, 2020	IPAC Subcommittee
November 10, 2020	IPAC Subcommittee

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

The Consumer Directed Employer (CDE) program will transfer the administrative functions and responsibilities of personal care and respite Individual Provider (IP) management from the Department of Social and Health Services (DSHS) and Area Agency on Aging (AAA) staff to a contracted CDE vendor, the Consumer Direct Care Washington, LLC. Participants (also referred to as consumers) will retain the authority to select, supervise, manage, and dismiss their IPs. The CDE must be responsive to the needs of participants, families, the IP workforce, and DSHS. Person-centeredness and self-directed care remains the top priority in the implementation of the CDE.

When an IP is chosen by a participant, the participant refers the IP for hiring to the CDE. If qualified, the IP is hired and becomes an employee of the CDE. The CDE is the legal employer and will be responsible for payroll, tax reporting, tracking paid leave, and credentialing of IPs. The CDE is also responsible for electronic visit verification for IPs, billing in the MMIS system, and withholding taxes and garnishments. The CDE will also engage in collective bargaining with the exclusive representative for the IP workforce.

The total estimated number of participants who have the choice to receive care through an IP and could access an IP through this waiver is approximately 50,000. At the time of this application, the estimated number of participants actually receiving personal care or respite through an individual provider is approximately 44,000.

The first phase of the transition to the CDE will begin October 1, 2021 based on geographical area, with statewide implementation in 2022.

Waiver Services:
Please list all existing State Plan services the State will provide through this selective contracting waiver.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   _X__ **1915(b) (4) - FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

   a._X_ **Section 1902(a) (1) - Statewideness**
   b.___ **Section 1902(a) (10) (B) - Comparability of Services**
   c._X__**Section 1902(a) (23) - Freedom of Choice**
   d.___ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

   __X_ the same as stipulated in the State Plan
   ___ is different than stipulated in the State Plan (please describe)

2. **Procurement**. The State will select the contractor in the following manner:

   _X__ **Competitive** procurement
   ___ **Open** cooperative procurement
   ___ **Sole source** procurement
   ___ **Other** (please describe)

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

   _X__ Beneficiaries will be limited to a single provider in their service area.
   ___ Beneficiaries will be given a choice of providers in their service area.

   (NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

2. **State Standards.**

   Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.
   The state is not changing the standards for the caregivers, only the entity who will hire and pay them.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations**. The following populations are included in the waiver:

___ Section 1931 Children and Related Populations
___ Section 1931 Adults and Related Populations
__X_Blind/Disabled Adults and Related Populations
__X_Blind/Disabled Children and Related Populations
__X_Aged and Related Populations
___ Foster Care Children
__X_Title XXI CHIP Children

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

___ Dual Eligibles
___ Poverty Level Pregnant Women
___ Individuals with other insurance
_X__Individuals residing in a nursing facility or ICF/MR
___ Individuals enrolled in a managed care program
___ Individuals participating in a HCBS Waiver program
___ American Indians/Alaskan Natives
___ Special Needs Children (State Defined). Please provide this definition.
___ Individuals receiving retroactive eligibility
___ Other (Please define):

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.,* what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

With the Consumer Directed Employer (CDE), the participant retains the ability to hire any qualified provider. Providers chosen by the participant are referred to the CDE to complete the hiring process. DSHS will measure timeliness of access to the service in

business days. The CDE vendor has a requirement via the contract performance standards to complete hiring activities for all IPs within 5 business days from the IP's completion of all required paperwork. After hiring activities are complete, the IP may begin providing services to the participant, based on the participant's direction, and for the authorized service hours. DSHS will monitor compliance with this performance standard at least on an annual basis looking for at least 98% compliance.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

Habitual non-performance on contract performance standards is grounds to declare the vendor in material breach. The contract allows DSHS the remedy to withhold payment for a portion of the rate until performance standards are met. DSHS can off-set damages incurred during the period of substandard performance. In the event of extended material breach, DSHS has the option to move those specific services to another vendor, negotiate changes to the services and compensation, or move to end the contract and find a new CDE vendor.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

The CDE provider is unique in that IPs are already in place. There are approximately 46,000 IPs authorized each month to provide in-home care. The transition to the CDE will follow a phased in approach based on geographical region beginning October 1, 2021 with statewide implementation in 2022. A phased in approach will ensure the vendor demonstrates sufficient capacity to provide contractual requirements, and allows time for correction before full implementation statewide. At the time of transition to the CDE, all current providers will be credentialed and working.

The CDE vendor must have capacity to provide administrative employer support services to the IPs. The services can be performed almost entirely remotely for the IPs. The DSHS contract requires the CDE vendor to provide in person support to IPs in all 39 counties in the state of Washington. DSHS has required the CDE vendor to agree to specific performance requirements for timeliness of service and specific outcomes. DSHS has also required the vendor to submit a staffing plan as part of their bid, and commit to adequately staffing the CDE in order to meet the contract requirements. DSHS will work with the vendor to monitor staffing levels and performance against contract requirements.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

As most of this work can be performed remotely, geographic distribution is not a significant risk for this provider type, although the vendor is required to have a local presence in all 39 Washington counties. DSHS will work with the CDE vendor to ensure that their local supports across the 39 counties are maintaining support levels that meet performance standards within the contract. This will be evaluated during the annual monitoring cycle as part of the performance standard monitoring.

For the transition to the CDE, a phased in approach will be used to allow for evaluation of each geographic region to ensure sufficient and timely access by clients.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

DSHS has included utilization as a performance standard of the CDE contract. DSHS will evaluate the number of authorized hours vs. claimed hours as well as overtime assignment and claims. A utilization baseline will be established prior to the CDE implementation of operations. DSHS will then monitor this utilization rate on at least an annual basis.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

Habitual non-performance on contract performance standards is grounds to declare the vendor in material breach. The contract allows DSHS the remedy to withhold payment for a portion of the rate until performance standards are met. DSHS can off-set damages incurred during the period of substandard performance. The vendor will continue to receive a portion of the overall rate to ensure the IPs are paid timely. In the event of extended material breach, DSHS has the option to move those specific services to another vendor, negotiate changes to the services and compensation, or move to end the contract and find a new CDE vendor.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

DSHS will review contract performance during the annual contracting cycle for the CDE vendor for all performance standards defined in the contract. This will include regular evaluation of ongoing operations, intermittent tasks, and tasks required only once per year.

ii. Take(s) corrective action if there is a failure to comply.

The CDE contract contains remedies for non-performance on the part of the vendor that include withholding of payment, requirements for a corrective action plan by the vendor, and a parent company guarantee, where applicable. DSHS may exercise these remedies for non-performance in any of the areas related to the quality of the service delivery as measured by the performance standards and contract requirements. Habitual non-performance on contract performance standards is grounds to declare the vendor in material breach. In the event of material breach, DSHS has the option to move those specific services to another vendor, negotiate changes to the services and compensation, or move to end the contract and find a new CDE vendor.

2. Describe the State's contract monitoring process specific to the selective contracting program.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

During operations of the CDE, DSHS will employ three full time employees to monitor the contract and perform quality assurance activities to evaluate the vendor's operations. This will include the annual review of vendor performance reporting described above, regular quality assurance oversight reviews of vendor systems and processes, and periodic formal audits including a SOC 2 Type II audit for 6 months of every year.

ii. Take(s) corrective action if there is a failure to comply.

DSHS will have all contract remedies available described above for breaches identified during contract monitoring.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

Coordination and continuity of care will be preserved with this selective contracting program because:

1. Clients will continue to direct how, when, and by whom the care services are provided.
2. Automation will be implemented to support communication between the CDE and the case managers regarding any potential disqualification of a client's caregiver (e.g., due to expiring training certification or background check) or when a change in caregiver has been requested by the client, or is otherwise needed (e.g., caregiver quits).
3. The CDE will offer assigned service coordinators to work with each client and their caregiver(s).
4. Case managers will continue to assess client needs and authorize care services, and provide ongoing case management services to the client.
5. The CDE will have staff in local communities available to assist clients face-to-face, by phone, or virtually with any questions or changes related to the employment or assignment of their caregiver(s).
6. Staff will receive training on communication protocols to ensure smooth collaboration between the CDE and case manager.
7. An escalation processes will be implemented and staff will be trained on when to invoke it should issues arise.
8. The CDE will have the ability to implement efficiencies that will decrease time in hiring and qualifying caregivers.
9. Clients will have access to a complaint resolution process which also includes an opportunity for appeals.
10. Clients will have access to a pool of potential caregivers who have met all worker qualifications through the IP referral registry. These are not on-call workers, but are people who have indicated they are interested in providing more hours if a client selects them to be an IP.
11. The CDE will continuously recruit and retain a skilled pool of available individual providers across the state.

In preparation for each implementation phase, the CDE will be responsible to complete all hiring activities for individual providers, and will receive demographic information transferred from the legacy system to the CDE. The hiring activities will begin no later than 3 months prior to the conversion. The CDE shall ensure a sufficient presence in all counties to support transition hiring activities for existing IPs.

In addition, the CDE will be responsible for tracking hiring progress, and providing this information to the state.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.
For beneficiaries, the transition to the CDE vendors should be seamless as participants will have the same care providers, only paid through the CDE vendor rather than the state. In order to keep beneficiaries informed of the process, several resources will be used to provide

information to participants. DSHS is engaging participants in readiness activities, such as webinars and a public website; will send a formal letter informing participants of the changes; and will send notice of the change in provider authorization prior to the transition. After implementation of the CDE, an informational brochure will be available to participants.

B. Individuals with Special Needs.

__X_ The State has special processes in place for persons with special needs (Please provide detail).

DSHS requires that vendors be able to communicate with clients and providers in ways that comply with the ADA. At a minimum, this includes TTY communication for people who have difficulty hearing.

DSHS also requires the CDE to work with authorized representatives of clients who are empowered to make decisions regarding the client's care.

Lastly, DSHS requires the CDE vendors to be able to communicate with providers and clients in languages other than English.

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

As this is a new way of doing business for the department, the department does not have a comparison of before and after costs. The following is a projected comparison of the selective contracting waiver costs (1 CDE vendor) with the cost of the same services with "any willing provider". The state estimates that there are likely no more than four providers that would be willing and qualified to act in this capacity with these increasing volumes.

Cost of multiple CDEs:
Vendor cost efficiencies - By having one CDE, DSHS will benefit from efficiencies in operations that will push down the overall costs in comparison to having multiple CDEs providing the same services. This is due to minimizing overhead and decreased profit margin expectations of one vendor performing these tasks for all IPs (46,000) vs. many vendors who have no certainty of the number of IPs they will cover (1,000-3,000). With fewer IPs to serve, but similar requirements for technology and overhead investment, vendors will charge more per participant in order to maintain profitability.

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: 10/01/2021 to 9/30/2022

Trend rate from current expenditures (or historical figures): 3%

Projected pre-waiver cost 60,913,000
Projected Waiver cost 41,090,000
Difference: 19,823,000

Year 2 from: 10/01/2022 to 9/30/2023

Trend rate from current expenditures (or historical figures): 3%

Projected pre-waiver cost 168,703,000
Projected Waiver cost 117,465,000
Difference: 51,238,000)

Year 3 (if applicable) from: 10/1/2023 to 9/30/2024
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost 154,280,000
Projected Waiver cost 109,277,000
Difference: 45,003,000

Year 4 (if applicable) from: 10/1/2024 to 9/30/2025
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost 160,187,000
Projected Waiver cost 113,437,000
Difference: 46,750,000

Year 5 (if applicable) from: 10/1/2025 to 9/30/2026
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost 164,973,000
Projected Waiver cost 116,829,000
Difference: 48,144,000

APPENDIX 6

Table of Contents

State/Territory Name: Washington

State Plan Amendment (SPA) #: 21-0011

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

September 16, 2021

Susan Birch, Director
Dr. Charissa Fotinos, Acting Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: Washington: Approval of 1915(b)(4) WA-15, 1915(c) HCBS waiver amendments (WA.0409.R03.11, WA.0410.R03.13, WA.1186.R01.08, WA.40669.R02.10, and WA.0443.R03.05), and 1915(k) State Plan Amendment (SPA) WA-21-0011

Dear Ms. Birch and Dr. Fotinos:

The Centers for Medicare & Medicaid Services (CMS) is approving Washington's application for an initial 1915(b)(4) Fee-For-Service Selective Provider Contracting Waiver, WA-15, titled Consumer Directed Employer (CDE). This initial 1915(b)(4) waiver will allow the state to transfer the administrative functions and responsibilities of personal care and respite Individual Provider (IP) management from the Department of Social and Health Services (DSHS) and Area Agency on Aging (AAA) staff to a single contracted CDE vendor, the Consumer Direct Care Washington, LLC. The 1915(b) waiver is authorized under section(s) 1915(b)(4) of the Social Security Act (the Act) and provides a waiver of the following section[s] of Title XIX:

- Section 1902(a)(1) Statewideness
- Section 1902(a)(23) Freedom of Choice

The decision to approve this 1915(b) waiver is based on the information submitted to CMS indicating that the state's proposal is consistent with the Medicaid program and will meet all statutory and regulatory requirements assuring beneficiaries access to care and quality services; and will demonstrate waiver cost-effectiveness for section 1915(b) waiver programs.

This 1915(b)(4) waiver will run concurrently with the following authorities:

- WA-21-0011 SPA -1915(k) Community First Choice/Optional State Plan Personal Care Services
- WA.0409.R03.11 –1915(c) Basic Plus Waiver
- WA.0410.R03.13 – 1915(c) Core Waiver
- WA.1186.R01.08 – 1915(c) Individual and Family Services (IFS) Waiver
- WA.40669.R2.10 – 1915(c) Children's Intensive In-Home Behavioral Support (CIIBS) Waiver
- WA.0443.R03.05 – 1915(c) New Freedom Waiver

The initial 1915(b) waiver is effective for 5 years beginning October 1, 2021 through September 30, 2026. The state may request renewal of the 1915(b) waiver by providing evidence and documentation of satisfactory performance and oversight. Washington's request that this authority be renewed should be submitted to the CMS no later than July 2, 2026. The state will report all managed care waiver expenditures on the CMS 64-9 report. Washington is responsible for documenting cost- effectiveness, access and quality in subsequent renewal requests. The state must arrange for an independent evaluation or assessment of the 1915(b)waiver program and submit the findings when renewing the section 1915(b) waiver program. At a minimum, the Independent Assessment (IA) is a requirement of the first two waiver periods. The IA should be submitted with the waiver renewal request ninety (90) days before the expiration of the approved waiver program, July 2, 2026.

Simultaneously, CMS is also approving the 1915(k) Community First Choice, Home and Community Based Services (HCBS) State Plan amendment (SPA), Transmittal Number WA-21-0011. With this amendment, the state is adding the Consumer Directed Employer (CDE) as the employer of individual providers within those State Plan services. This SPA is approved effective October 1, 2021, as requested by the state. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Washington State Plan.

In addition, CMS is approving your request to amend the following Washington §1915(c) Home and Community-Based Services (HCBS) waivers: Basic Plus, Core, Individual and Family Services (IFS), and Children's Intensive In-Home Behavioral Support (CIIBS) waivers for individuals with intellectual or developmental disability and the New Freedom waiver for individuals requiring a nursing facility level of care. The CMS Control Numbers for the waiver amendments are as follows: Basic Plus (WA.0409.R03.11), Core (WA.0410.R03.13), IFS (WA.1186.R01.08), CIIBS (WA.40669.R02.10), and New Freedom (WA.0443.R03.05). The amendments are approved effective October 1, 2021, as requested by the state.

The 1915(c) waiver amendments reference concurrent operation with a §1915(b)(4) waiver and reflects implementation of the Consumer Directed Employer (CDE), which will be the new employer of individual providers. Additionally, the Basic Plus, Core, IFS, and CIIBS waiver amendments make the following changes:

- Add Crisis Diversion Bed Provider (State-operated) to the Stabilization Services – Crisis Diversion Bed service;
- Add qualified Specialized Habilitation providers as qualified Staff/Family Consultation Service providers to Stabilization Services – Staff/Family Consultation Services;
- Add qualified Specialized Habilitation providers as qualified Staff/Family Consultation Services providers;
- Reference the transition to a Consumer Directed Employer (CDE), who will become the employer of Respite Individual Provider (IP) waiver providers;
- Reference concurrent operation with a §1915(b)(4) waiver;
- Revise Respite provider qualifications for independent providers to conform with implementation of CDE in concurrent §1915(b)(4) waiver;
- Increase participant capacity based on new legislative funding;
- Revise estimates for utilization and expenditures for waiver services to reflect increased estimates;

- Add and revise language in various performance measures;
- Revise service estimates in Appendix J to increase the number of users and increase the cost per unit for respite.
- For the Basic Plus waiver, correct a cost per unit error for staff/family consultation that was approved in the previous amendment;
- For the Core waiver, revise provider qualifications for Child Foster Home for Residential Habilitation;
- For the IFS waiver, increase the annual budget allocation for waiver services by 30%
- For the CIIBS waiver, revise service estimates in Appendix J to increase the number of users and increase the cost per unit for respite and adjusted the number of users in Specialized Equipment and Supplies to account for replacing an old service and increased the number of users. Average units per user was also decreased for multiple services in WY5 to account for the phasing-in of new participants.

With respect to the 1915(c) waiver amendments, this approval is subject to your agreement to serve no more individuals than the total number of unduplicated participants indicated in Appendix J.2 of the waivers. If the state wishes to serve more individuals or make any other alterations to these waivers, an amendment must be submitted for approval.

It is important to note that CMS' approval of these waivers solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

We appreciate the cooperation and effort provided by you and your staff during the review of these actions. If you have any questions concerning this information, please contact Nick Sukachevin at (206) 615-2416 or via email at Nickom.Sukachevin@cms.hhs.gov for the 1915(c) waivers and 1915(k) SPA, or Tonya Dobbin at (410) 786-3032 or via email at Tonya.Dobbin@cms.hhs.gov for the 1915(b) waiver.

Sincerely,

[redacted]ly signed by George
la Jr -S
2021.09.16
10 -04'00'

George P. Failla, Jr., Acting Director
Division of HCBS Operations and Oversight

[redacted]Digitally signed by Carrie
ith -S
2021.09.16
9:51 -05'00'

Carrie Smith, Deputy Director
Disabled and Elderly Health Programs Group

Cc:
Debbie Roberts, DSHS
Beth Krehbiel, DSHS
Ann Vasilev, DSHS
Jamie Bond, DSHS
Bob Beckman, DSHS
Stephen Kozak, HCA
Bill Moss, DSHS
Bea-Alise Rector, DSHS
Alec Graham, DSHS
Jamie Tong, DSHS
Barbara Hannemann, DSHS
Grace Brower, DSHS
Ann Myers, HCA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **21-0011**

2. STATE: Washington

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
October 1, 2021

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:
1902(a) & 1915(k) of the Social Security Act; Title 42 Part 441 CFR

7. FEDERAL BUDGET IMPACT:
a. FFY 2022 $42,603,000
b. FFY 2023 $54,435,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A page 65
Attachment 3.1-K pages 2, 6, 6a (new)
Attachment 4.19-B pages 31, 32, 46, 48, 49

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1-A page 65
Attachment 3.1-K pages 2, 6
Attachment 4.19-B pages 31, 32, 46, 48, 49

10. SUBJECT OF AMENDMENT:

Consumer Directed Employer

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: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
MaryAnne Lindeblad

14. TITLE:
Medicaid Director

15. DATE SUBMITTED:
03-30-2021

16. RETURN TO:
Ann Myers
Rules and Publications
Division of Legal Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
3/30/2021 (initial submission)
7/1/2021 (submission of response to formal RAI)
9/9/2021 (resubmission of response to formal RAI)

18. DATE APPROVED: 9/16/2021

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/1/2021

20. SIGNATURE OF REGIONAL OFFICIAL:
George P. Failla Jr -S
Digitally signed by George P. Failla Jr -S
Date: 2021.09.16 13:30:56 -04'00'

21. TYPED NAME: George P. Failla, Jr.

22. TITLE: Acting Division Director, DHCBSO

23. REMARKS:
5/26/21: State authorized P&I change to Box 8 and 9.
6/3/21: State authorized P&I change to Box 7.
8/17/21: State authorized P&I change to Box 8.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

26. Personal care services

a. Eligibility for services.
Persons must living in their own home, Adult Family Home, family foster home, or assisted living facility.

b. Persons must be determined to be categorically needy and have three ADL needs requiring minimal assistance or one ADL need requiring more than minimal assistance. Personal care services means physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to functional limitations. ADL assistance means physical or verbal assistance with bathing, turning and repositioning, body care, dressing, eating, mobility, medication assistance, toileting, transfer, personal hygiene, nurse delegated tasks, and self-directed treatment. IADL assistance is incidental to the provision of ADL assistance and includes ordinary housework, laundry, essential shopping, wood supply (if wood is the primary source of heat) and transportation assistance.

c. Persons receiving personal care from an Individual Provider employed by the Consumer Directed Employer have co-employer authority including selecting, dismissing, scheduling and supervising providers.

d. Services are provided by these provider types:
- State-licensed agencies providing personal care services, consisting of licensed home-care agencies and licensed adult residential care providers who are contracted with the Department. Home health agencies providing personal care services do not require Medicare certification;
- State-licensed adult residential care providers; and
- Consumer Directed Employer of Individual providers who have a valid Washington business license, demonstrated financial stability, five years' experience in healthcare or social service, meet staffing requirements, have a commitment to consumer choice and self-direction and are contracted with the Department. The CDE will ensure that individual providers who provide personal care:
    - Clear background checks as required by state law;
    - Complete training and certification as required under state law; and
    - Complete continuing education credits as stipulated in state law in order to continue to provide personal care services.

The transition to the CDE will not impact the assessment process. Participants will not lose eligibility, services, or receive a reduction in services as a result of the transition to a CDE provider. Although the state will constrict the CDE provider pool with a 1915(b)(4) waiver of free choice of providers, participants will still be able to select their Individual Providers from a pool of any willing and qualified providers and continue to receive services in at least the same amount, duration, and scope. The state will not be reducing the rates of personal care services. Individual Providers will continue to receive at least the same rates as prior to the enactment of the CDE.

Individual providers of the CDE may not work more than the provider's assigned work week limit. This limitation does not affect the participant's total hours of service and may necessitate the use of more than one provider.

f. For individuals under 21 years of age, services will be provided in accordance with EPSDT requirements at 1905(r) subject to determination of medical necessity and prior authorization by the Medicaid Agency.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Washington

Community First Choice State Plan Option

I. Service Delivery Models

__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 entities under a contract.

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

____ Direct Cash
____ Vouchers
____ Financial Management Services in accordance with 42 CFR 441.545(b)(1).

_____ Other Service Delivery Model as described below:

II. Use of Direct Cash Payments

The State elects not to disburse cash prospectively to CFC participants.

III. Service Package

a. The following are included CFC services including service limitations:

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

1. **Personal Care Services:** Personal care services means hands-on assistance, supervision, and/or cueing with activities of daily living (ADL), instrumental activities of daily living (IADL), and health-related tasks due to functional limitations. ADLs include: bathing, bed mobility, body care, dressing, eating, locomotion, medication management, toilet use, transfers, and personal hygiene. IADL assistance is incidental to the provision of ADL assistance and includes: meal preparation, ordinary housework, essential shopping, ensuring wood supply when wood is the primary source of heat, and travel to medical services. Health-related tasks are 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 an attendant.

   The provision of assistance with ADLs, IADLs, and health-related tasks can be provided concurrently with skills acquisition training.

   Participants are offered a choice of residential-based care or in-home care provided by a home care agency provider or by an individual provider employed by the Consumer Directed Employer (CDE). Participants receiving personal care from an individual provider employed by the CDE have employer authority including selecting, dismissing, scheduling, and supervising providers. The participant determines the schedule and

1. Security deposits that are required to obtain a lease on an apartment or home, including first month's rent;
2. Essential household furnishings required to occupy and use a community domicile, including, but not limited to, furniture, window coverings, food preparation items, and bath/linen supplies;
3. Set-up fees or deposits for utilities and/or service access, including telephone, electricity, heating, water, and garbage;
4. Services necessary for the participant's health and safety such as pest eradication and one-time cleaning prior to occupancy;
5. Moving expenses; and
6. Activities to assess need, arrange for, and procure needed resources.

Community Transition Services may not exceed $850.00 per occurrence with no limitations on number of transitions in any given time frame. This limit may be exceeded based on medical necessity.

V. Qualifications of Providers of CFC Services

a. All personal care providers are required to complete Basic training. The number of hours for Basic training varies depending on the current credentials of the provider, the relationship of the provider to the participant, and how many hours the provider works. Unless exempt by state rule, all personal care providers must obtain certification as a Home Care Aide. The Basic training covers basic skills and information needed to provide hands-on personal care, and may also include population-specific training if the provider is trained to meet the needs of a specific population. Once training is complete, unless exempt by state rule, the provider must take and pass a written and a skills examination through the Washington State Department of Health to become certified as a Home Care Aide.

b. Residential and non-residential settings in this program comply with federal HCB Settings requirements at 42 CFR 441.530 and associated CMS guidance. The State will provide comprehensive initial and ongoing training for all ALF and AFH providers on HCB setting rules and regulations. Additional HCB setting training will be provided periodically to individual ALF and AFH providers when needed.

i. **Personal Care, Relief Care, and Nursing Providers:**
Consumer Directed Employer of Individual Providers: Must have a valid Washington business license, demonstrate financial stability, have five years' experience in healthcare or social service, meet staffing requirements, have a commitment to consumer choice and self-direction, and be contracted with the Department before being paid to provide personal care services. The CDE will ensure that individual providers who provide personal care:
   a. Clear background checks as required by state law;
   b. Complete training and certification as required under state law; and
   c. Complete continuing education credits as stipulated in state law in order to continue to provide personal care services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

The transition to the CDE will not impact the assessment process. Participants will not lose eligibility, services, or receive a reduction in services as a result of the transition to a CDE provider. Although the state will constrict the CDE provider pool with a 1915(b)(4) waiver of free choice of providers, participants will still be able to select their Individual Providers from a pool of any willing and qualified providers and continue to receive services in at least the same amount, duration, and scope. The state will not be reducing the rates of personal care services. Individual Providers will continue to receive at least the same rates as prior to the enactment of the CDE.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XV. Personal Care Services

State-developed fee schedule rates are the same for both governmental and private providers of the same service. See 419-B.I, General, for the agency's website where the fee schedules are published.

A. Payment for services

Services are provided by these provider types:

- State-licensed agencies providing personal care services, consisting of licensed home-care agencies. Home health agencies providing personal care services do not require Medicare certification.
- Adult residential care providers who are licensed by Department of Social and Health Services (DSHS) according to DSHS Revised Code of Washington (RCW) and Washington Administrative Code (WAC) as follows:
  - Assisted Living Facilities – chapter 18.20 RCW and chapter 388-78A WAC. Must be licensed as an assisted living facility. Care givers must be at least 18 years of age, have cleared initial background checks as required by state law and remain free of disqualifying crimes or negative actions, complete training requirements outlined in chapter 388-112A WAC and be authorized to work in the United States.
  - Adult family home – chapter 70.128 RCW and chapter 388-76 WAC. Must be licensed as an adult family home. Provider/resident manager must be at least 21 years of age and have a high school diploma or general education development certificate. Care givers must be at least 18 years of age. Provider/resident manager and care givers must clear initial background checks as required by state law and remain free of disqualifying crimes and/or negative actions, maintain current CPR and first aid certificate, complete training requirements outlined in chapter 388-112A WAC, and be authorized to work in the United States.
- Individual providers of personal care employed by the Consumer Directed Employer (CDE). The CDE must certify individual providers:
  - Are age 18 or older;
  - Are authorized to work in the United States;
  - Have cleared the initial state background checks and remain free of disqualifying crimes and/or negative actions; and
  - Complete training and certification requirements outlined in chapter 388-71 WAC

Payment for services provided by agency and individual providers employed by the CDE are reimbursed at an hourly unit rate, and payment for residential-based services is reimbursed at a daily rate. All providers will submit claims in the state MMIS system for personal care services.

No payment is made for services beyond the scope of the program or hours of service exceeding the Medicaid Agency's authorization. Payments to residential providers are for personal care services only, and do not include room and board services that are provided. Payment is made only for the services described in Attachment 3.1-A, section 26

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XV. Personal Care Services (cont)

B. Service Rates

State-developed fee schedule rates are the same for both governmental and private providers of the same service. The fee schedule is published at https://www.dshs.wa.gov/sites/default/files/ALTSA/msd/documents/All_HCS_Rates.xls. The fee schedule was set as of July 1, 2021, to be effective for dates of service on and after July 1, 2021.

1. The rate paid to the CDE for providing personal care services by individual providers is an hourly rate which covers the individual provider service hour and employer functions performed by the CDE, which include hiring and qualification verification, payroll activities, call center support, employee visit verification system, and other legally required employer functions. The hourly rate is determined by a rate setting board and is subject to approval by the State legislature. The rate for personal care services provided by individual providers through the CDE consists of wages, industrial insurance, paid time off, mileage reimbursement, comprehensive medical, training, seniority pay, training-based differentials, and a retirement plan.

2. The rate paid to home care agencies for providing personal care is an hourly rate that consists of home care worker compensation, benefits, and taxes, as defined in state parity law, and an additional amount for employer functions performed by the agency.

3. The rate paid to assisted living facilities for providing personal care is based on a per day rate. Each participant is assigned to a classification group based on the State's assessment of their personal care needs. The daily rate varies depending on the individual's classification group. The rates are based on components for provider staff, operations, and capital costs. The rate paid to residential providers does not include room and board.

4. The rate paid to an adult family home for providing personal care is based on a per day rate and is determined by the State legislature, based on negotiations between the Governor's Office and the union representing Adult Family Homes.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Washington
Community First Choice State Plan Option

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

XXI. First Choice State Plan Option

State-developed fee schedule rates are the same for both governmental and private providers of the same service. The fee schedule is published at:
https://www.dshs.wa.gov/sites/default/files/ALTSA/msd/documents/All_HCS_Rates.xls.
Rates for Personal Care and Nurse Delegation provided under 1915(k) are the same as the payment rates for Personal Care and Nurse Delegation services listed in Attachment 4.19-B, XV Personal Care Services. Rates for Nurse Delegators provided under 1915(k) are the same as the payment rates for Nurse Delegators under Attachment 4.19-B, XV Personal Care Services. Payment rates for 1915(k) services will be updated whenever the fee schedule is updated on the corresponding State Plan page under the existing Personal Care Services benefit.

A. PERSONAL CARE

Personal care service providers:

1. Individual providers employed by the Consumer Directed Employer (CDE)
2. State-licensed home-care agencies
3. Residential service providers which include:
   a. Assisted living providers
   b. Adult family homes

Personal care service provider rates:

1. Individual providers employed by the CDE
   The rate paid to the CDE for providing personal care by individual providers is an hourly rate which covers the individual provider service hours and employer functions performed by the CDE, which include hiring and qualification verification, payroll activities, call center support, employee visit verification system, and other legally required employer functions. The hourly rate is determined by a rate setting board and is subject to approval by the State legislature. The rate for personal care services provided by individual providers through the CDE consists of wages, industrial insurance, paid time off, mileage reimbursement, comprehensive medical, training, seniority pay, training-based differentials, and a retirement plan.

2. State-licensed home-care agencies
   The rate paid to home care agencies for providing personal care is an hourly rate that consists of home care worker compensation, benefits, and taxes, as defined in state parity law, and an additional amount for employer functions performed by the agency.

3. Residential service providers
   The rate paid to adult family homes and assisted living facilities for providing personal care is paid at a daily rate. Each participant is assigned to a classification group based on the State's assessment of their personal care needs. The daily rate varies depending on the individual's classification group. Rates are based on wages, benefits, and administrative expenses.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

XXI. First Choice State Plan Option (cont)

B. SKILLS ACQUISITION TRAINING

Skills acquisition training service providers:

1. Individual providers of personal care employed by the CDE
   The CDE is reimbursed an hourly rate which covers the individual provider service hours and employer functions, which include hiring and qualification verification, payroll activities, call center support, employee visit verification system, and other legally required employer functions. The hourly rate is determined by a rate setting board and is subject to approval by the state legislature. The rate for personal care services provided by individual providers through the CDE consists of wages, industrial insurance, vacation pay, mileage reimbursement, comprehensive medical, training, seniority pay, training-based differentials, and a retirement plan.

2. State-licensed home-care agencies
   Home care agencies are reimbursed an hourly rate that consists of home care worker compensation, benefits, and taxes, as defined in state parity law, and an additional amount for employer functions performed by the agency.

3. State–certified supported living agencies who are recruited and at the local level by Area Agencies on Aging, and Department field offices. Agencies are paid an hourly rate that must be within the range published by the Department where applicable and shall not be higher than, 1) the prevailing charges in the locality for comparable services under comparable circumstances; or 2) the rates charged by the contractor for comparable services funded under other sources.

4. Home Health Agencies
   Home Health Agencies are reimbursed per-visit for services provided by acute nursing staff, physical therapy, occupational therapy, speech, hearing and language disorders therapy staff, and home health aides.

   Reimbursement rates are determined using a historical base for the per-visit rates by profession, using the Medicare Metropolitan Statistical Area fees. Each year the State updates those per-visit rates using the state's annually published vendor rate adjustment factor.

   The Medicaid agency pays the lesser of the usual and customary charge or a fee based on a Medicaid agency fee schedule for these services.

   Rates for Home Health Agencies paid to provide skill acquisition services will be the same as those paid under attachment 4.19 B page 19 of the Plan. Except as otherwise noted in the Plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of Home Health.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

XXI. First Choice State Plan Option (cont)

All rates, including current and prior rates, are published and maintained on the agency's website. Payment rates for 1915(k) services will be updated whenever the fee schedule is updated on the corresponding State Plan page under the Home Health benefit.

The State will reimburse up to $550.00 per fiscal year in costs for Skills Acquisition training alone or in combination with Assistive Technology.

C. BACK-UP SYSTEMS

Backup System service providers include:

1. Individual providers of personal care employed by the CDE. The CDE is reimbursed an hourly rate for individual provider services and employer functions, which include hiring and qualification verification, payroll activities, call center support, employee visit verification system, and other legally required employer functions. The hourly rate is determined by a rate setting board and is subject to approval by the State legislature. The rate for personal care services provided by individual providers through the CDE consists of wages, industrial insurance, vacation pay, mileage reimbursement, comprehensive medical, training, seniority pay, training-based differentials, and a retirement plan.

2. State-licensed home-care agencies are paid an hourly rate that consists of home care worker compensation, benefits, and taxes as defined in state parity law, and an additional amount for employer functions performed by the agency.

3. Personal Emergency Response vendors are paid a one- time rate for initial equipment and set up and are then paid a monthly service charge. Rates must be within the ranges published by the Department where applicable and shall not be higher than, 1) the prevailing charges in the locality for comparable services under comparable circumstances; or 2) the rates charged by the contractor for comparable services funded under other sources.

D. VOLUNTARY TRAINING ON HOW TO SELECT MANAGE AND DISMISS ATTENDANTS (Caregiver Management)

Peer Support Specialist and Community Choice Guides are reimbursed on an hourly rate The Department pays a rate negotiated with the providers. Payment cannot exceed, 1) the prevailing charges for comparable services in the locality under comparable circumstances; or 2) the rates charged by the contractor for comparable services funded by other sources.

APPENDIX 7

Table of Contents

State/Territory Name: New York

State Plan Amendment (SPA) #: 13-0035

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

October 23, 2015

Jason A. Helgerson
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. Helgerson:

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **13-0035**

2. STATE: **New York**

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2015

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:
§ 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)*:
☒ 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: **Jason A. Helgerson**

14. TITLE: **Medicaid Director**
Department of Health

15. DATE SUBMITTED: DEC 30 2013

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

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:
[redacted]

21. TYPED NAME:
MICHAEL A. MELENDEZ

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:

FORM HCFA-179 (07-92)

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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 waivered 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.

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.

New York
6(a)(v)

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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6(a)(vi)

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

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

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6(a)(vii)

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
4722, 4723, 4724, 4725, 4741, 4742, 4743, 4744, 4755, 4756, 4757, 4758, 4765, 4766, 4767, 4768, 4796, 4797, 4798, 4799	Community Habilitation	N/A	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)

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

Rate Code	Service	Current Rate	Methodology
2609, 2616, 2809, 2818, 3823, 3831, 3858, 9981	Personal Emergency Response (PERS)	$23.11/month*	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

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

New York
6(a)(viii)

4. Permissible services/Substitute for human assistance

Rate Code	Service	Current Rate	Methodology
3143, 4482, 4483, 4484, 4485, 9752	Assistive Technology	100% of claim determined reasonable by the state.	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. https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_06/assistive_technology.htm
9750	Vehicle Adaptation	100% of billed cost determined reasonable by the state	NHTD current methodology, limit $15,000; separate from e-Mods limit https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/nhtd_program_manual_with_forms.pdf
3144, 4786, 9758, 9867	Community Transitional Services (establishing a household in the community from an institutional setting)	100% of claim/approved cost	One-time payment not to exceed $5,000. Specific amount will be based on State review and approval of cost projections.
N/A	Durable Medical Equipment		Fee schedule available at: https://www.emedny.org/ProviderManuals/DME/index.aspx
4476, 4477, 4478, 4479, 9992, 9995, 9998, 9762, 9874	Environmental Modifications	100% of claim determined reasonable by the State	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: https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_06/e-mods.htm

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6(a)(ix)

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

Rate Code	Service	Current Rate	Methodology
2682, 2685, 2835, 3874, 9781	Home Delivered Meals	$5.79/Meal*	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
2638, 2830, 3872	Congregate Meals	$5.07/Meal*	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
2636, 2831, 3870, 9787	Moving Assistance (transport of personal belongings)	$58.79/hr*	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

*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.

APPENDIX 8

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SMD # 16-011

RE: Community First Choice State Plan Option

December 30, 2016

Dear State Medicaid Director:

This letter provides guidance on the implementation of the Community First Choice State Plan Option, a home and community-based benefit package available to states to promote community integration. Section 2401 of the Affordable Care Act amended section 1915 of the Social Security Act (the Act) to add 1915(k) as a new subsection, the benefit known as Community First Choice (CFC). Under section 1915(k) of the Act, states have the option to amend their state plan to provide home and community-based attendant services and related supports. CFC final regulations[1] were published May 7, 2012, and the final regulations for home and community-based setting requirements for CFC[2] were published January 16, 2014. CMS is committed to helping support states interested in adding the CFC option to their Medicaid state plan, and to aid in that effort we are providing a state plan amendment (SPA) pre-print and CFC technical guide.

Background

The purpose of the CFC option is to provide individuals meeting an institutional level of care the opportunity to receive necessary personal attendant services (PAS) and supports in a home and community-based setting. The CFC option expands Medicaid opportunities for the provision of home and community-based long-term services and supports (LTSS) and is an additional tool that states can use to facilitate community integration while receiving enhanced Federal match of six (6) additional percentage points for CFC services and supports. There is a growing trend towards home and community-based services instead of institutional care. In 2013, 51.3 percent of the dollars spent nationally on Medicaid LTSS was for community-based supports, signifying the first time Medicaid expenditures for these services exceeded institutional care. In 2014, the percentage grew to 53.1 percent.[3] It is clear that CMS and states are committed to making additional progress, and the CFC benefit can be used to expand the availability and scope of LTSS. This can include reinvesting the additional Federal Medical Assistance Percentage (FMAP) to provide new PAS, increase the comprehensiveness of existing PAS, and enhance the state's overall LTSS program.

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[1] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/cfc-final-regulation.pdf

[2] https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

[3] Wenzlow, Audra, Steve Eiken, and Kate Sredl. 2016. *Improving the balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014.* Prepared for CMS by Truven Health. Retrieved from https://www.medicaid.gov/medicaid/ltss/downloads/evolution-ltss-expenditures.pdf

As states continue to engage stakeholders in the development of home and community-based services, CMS encourages consideration of CFC as a meaningful option to rebalance long-term care expenditures and increase the availability of home and community-based options.

CFC can help reduce the administrative complexity that results from having multiple authorities to provide similar types of services across different populations. While different benefit authorities, such as 1915(c) Home and community-based waivers and 1915(i) Home and community-based state plan services, may provide states the flexibility to target services and populations, this may result in inconsistency in the levels and types of services available across populations. It may also make it difficult to manage and coordinate services across programs with different eligibility criteria and different assessment tools in use. The CFC option allows services to be available across populations for people who meet the institutional level of care, in accordance with need and regardless of the type, nature or severity of disability, thus making it possible to standardize eligibility and needs assessments while better coordinating services.

PAS are utilized by individuals across all conditions and disabilities, and there is not one population with an institutional level of care need that would benefit from PAS more than another. Making services available to individuals across all institutional levels allows states to streamline access to PAS, by focusing on an individual's functional needs, rather than type of disability. CFC offers states the opportunity to provide personal assistance and related services in a coordinated manner that highlights self -direction, person-centered planning, and flexible service delivery.

Individuals receiving CFC services are not precluded from receiving other home and community-based long-term care services and supports through other Medicaid state plan, waiver, grant, or demonstration authorities. The CFC benefit should be used in conjunction with other services (Medicaid funded and non-Medicaid funded) to support an individual's opportunity for full community integration.

Enhanced Federal Medicaid Assistance Percentage (FMAP)

States will receive a six percentage point increase to the FMAP calculated under 1905(b), not to exceed 100 percent, for the provision of CFC services and supports. For example, a state that regularly receives 50 percent FMAP would receive a six percentage point increase resulting in 56 percent FMAP for services authorized through the CFC state plan option. The enhanced FMAP is only applicable for the provision of CFC supports and services provided directly to individuals who meet the eligibility requirements described in 42 CFR 441.510 (such as attendant care services, person-centered planning, and financial management services). States must adhere to the free choice of provider requirements at 42 CFR 431.51, unless provided through a managed care arrangement or authorized under selective contracting authority.

There are various activities that are performed for the proper and efficient administration of the Medicaid state plan, including for activities related to CFC services, such as level of care determinations, quality management, data collection, implementation of the Development and Implementation Council required under CFC and administrative costs related to implementation of a fiscal agent structure. The state expenditures for these activities will be matched at the 50 percent administrative claiming rate, rather than the CFC enhanced match.

To the extent a state seeks administrative match for the above mentioned activities, and the activities have not been documented within either a state's Public Assistance Cost Allocation Plan (PACAP) or a Medicaid Administrative Claiming (MAC) Plan, the state will have to amend its PACAP or MAC Plan to document these activities and receive administrative match. CMS is available to provide technical assistance on any needed amendments.

Program Eligibility

Section 1915(k) of the Act did not create a new eligibility category for the CFC state plan option. Therefore, coverage for 1915(k), like other state plan services, is dependent on an individual meeting all of the requirements for a Medicaid eligibility category covered under the state plan to which the 1915(k) benefit is made available.

Individuals who are eligible for medical assistance under the HCBS waiver-related category described in §435.217 ("Individuals receiving home and community-based services") must meet all the 1915(c) waiver requirements, including the receipt of the minimum number of waiver services identified in the waiver, to maintain eligibility for medical assistance and access the CFC state plan option. Receipt of state plan 1915(k) services is not a basis for maintaining Medicaid eligibility for this category.

The CFC benefit includes specific program eligibility criteria that states must adhere to when determining who can receive the CFC benefit. These requirements are summarized as follows:

Level of Care Requirement (42 CFR 441.510)

Individuals receiving CFC benefits must meet one of the following institutional levels of care: (long-term) hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over. States must include all levels of care required by the CFC statute and implementing regulations that are covered in their state. States may not develop a CFC benefit that is targeted to a specific population. For example, a CFC benefit could not only be available to individuals who meet a nursing facility level of care. States must have a process to determine CFC eligibility for individuals based on the level of care for the setting in which the individuals would have received institutional services.

Financial Eligibility

In addition to being eligible for Medicaid under the state plan authority, individuals must meet one of two eligibility requirements specific to the CFC benefit. If an individual is in an eligibility category covered under the Medicaid state plan to which coverage for nursing facility services is available, no separate income test is applied to determine the individual's eligibility for coverage of CFC (§441.510(b)(1)). However, if an individual is not in such an eligibility category, the individual not only must meet any income test applicable to the Medicaid eligibility group, but must have income that is at or below 150 percent of the federal poverty level (FPL) in order to be eligible to receive coverage of CFC (§441.510(b)(2)). The determination of whether an individual's income is at or below 150% of the FPL must be based on the same methodologies as would apply to the category under the Medicaid state plan in which the individual is enrolled, including application of any disregards approved under the state plan in accordance with section 1902(r)(2) of the Act.

Additionally, section 2404 of the Affordable Care Act mandates that, for the five-year period beginning January 1, 2014, the definition of an "institutionalized spouse" in section 1924(h)(1) of the Social Security Act (the spousal impoverishment statute) includes married individuals who are eligible for, among other things, "medical assistance for home and community-based attendant services and supports under section 1915(k). . . ." The Centers for Medicare & Medicaid Services (CMS) issued 2015 guidance to states on how this provision should be applied ("Affordable Care Act's Amendments to the Spousal Impoverishment Statute"). CMS reminds states that are interested in adopting, or have adopted, the 1915(k) benefit that Medicaid

eligibility for married individuals should be determined in a manner consistent with our May 2015 guidance, which can be found at: http://www.medicaid.gov/federal-policy-guidance/downloads/SMD050715.pdf

CFC Services (42 CFR 441.520)

There are required services that must be included in all CFC programs, as well as additional services that may be included at the state's option. There is no requirement that every service that is included in the CFC benefit will be provided to every individual receiving the benefit. States are required to complete an assessment of each individual, and to identify and provide those CFC services and supports that are determined to be necessary and appropriate. All services and items must be linked to an assessed need and identified in the person-centered plan (described in more detail below).

States electing CFC are required to cover the following services, subject to the conditions described above: (1) activities of daily living (ADLs),instrumental activities of daily living (IADLs) and health-related tasks, through hands-on assistance, supervision, and/or cueing; (2) acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs and IADLs and health-related tasks; (3) back-up systems or mechanism to ensure continuity of services and supports; and (4) voluntary training on how to select, manage, and dismiss attendants.

The optional services states may cover in their CFC benefit include: (1) expenditures for transition costs (such as first month's rent and utilities or bedding, basic kitchen supplies, etc.) necessary for an individual transitioning from an institutional setting to a home and community-based setting and (2) expenditures relating to a need that increases an individual's independence or substitutes for human assistance, to the extent that Medicaid expenditures would otherwise be made for human assistance. For example, an attendant assisting an individual with transferring from sitting to standing would be considered an ADL, and therefore, considered a covered CFC activity. In lieu of having an attendant on "stand-by" to assist with this activity, the individual may indicate through the person-centered service plan that he would like an electric seat lift so that he can get out of his chair independently. Under this activity, the state could cover the cost of the seat lift, so an individual can get up and sit down independently, instead of needing to have an attendant to provide that type of assistance.

States have a degree of flexibility to determine the scope of what to include in transitional costs and items that increase independence or substitute for human assistance. It is not necessary for the state to list every service or support that would be covered for this purpose; however, in accordance with general Medicaid requirements found at 42 CFR 440.230(a), a state must describe any limitations on the amount, duration or scope of any of the required and optional services. The attached CFC technical guide provides additional information regarding the scope of the benefit and the examples of the optional services that may be included.

Service Models (42 CFR 441.540)

There are three service delivery models available to states to include in their CFC benefit. While each model will have varying levels of responsibilities afforded to the individual, all models must offer a consumer controlled method of selecting and obtaining services that allows the individual the maximum control possible.

Services may be provided through (1) an agency-provider model, (2) a self- directed model with a service budget (utilizing a financial management entity and/or direct cash payments or vouchers), or (3) a state defined model that is approved by the Secretary. The state determines service delivery model(s) to include in its CFC benefit.

Person-Centered Planning Process and Service Plan (42 CFR 441.540)

The person-centered planning process identifies a person's strengths, goals, preferences, service needs and desired outcomes. It is a process that is driven by the individual[4] receiving services and must allow for the participation of people freely chosen by the individual. These people can be family members, friends, caregivers, and others the individual or his/her representative wishes to include. The process must involve the individual receiving services and supports to the maximum extent possible, even if the individual has a legal representative.

The person-centered service plan reflects the services and supports (paid and unpaid) that are important for the individual. These services are to assist the individual to address the needs identified through an individual assessment of functional need and the goals identified by the individual. The services must also reflect the individual's preferences for the delivery of CFC services and supports. Like the person-centered planning process, the development of the person-centered service plan must be driven by the individual receiving CFC services. In order to accomplish this, a support system must be available as part of the CFC benefit and provided in accordance with the requirements described in §441.555. In summary, the support system must provide individuals with counseling, information, training, skills and supports they need to make informed choices and decisions. Counseling would include providing information on the range of service options and choices available, grievance and appeal rights, and information on freedom of choice of providers and service models. Training would include training individuals on the rights and responsibilities of directing the provision of services, such as how to communicate effectively with attendants and how to supervise attendants. The role of individuals providing support activities (e.g., options counselors, support brokers, social workers and others) in the person-centered planning process is to enable and assist individuals to identify and access a unique mix of paid and unpaid services to meet their needs, and provide support during the planning process.

In addition to the services and supports available through the CFC benefit, natural supports provided by unpaid caregivers play a critical role in assisting individuals with remaining in the community. As noted in the response to the comment in the preamble of the CFC final regulation (CMS-2337-F), the identification of natural supports in the assessment is an important aspect in determining an individual's needs. 42 CFR 441.540(b)(6) states that "Natural supports cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual in lieu of the attendant." CMS is clarifying that this language is to set forth the requirement that informal caregivers, family members and friends cannot be required to provide unpaid supports as a condition of an individual receiving CFC services, nor can the beneficiary be required to accept such services. Informal caregivers, family members and friends should only provide unpaid supports if they and the individual determine it is their preferred option based on the assessment, the person-centered planning process, the approved levels of paid support in the plan and in accordance with the service delivery model(s) selected by the state. This requirement does not require that caregivers that were previously unpaid should become paid caregivers under the CFC benefit, nor does this require that caregivers need to be paid beyond the paid hours authorized in the plan.

Lastly, to prevent conflicts that may arise when an individual's representative could also provide paid services, CFC regulations prohibit an individual's representative, as defined in 42 CFR 441.505, from also being paid to provide CFC services to the individual. In circumstances where it has been determined that the representative is the most appropriate person to provide services, an alternative person must be identified to act as the individual's representative for the purposes of participating in the person-centered planning process and provision of CFC services and supports.

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[4] In accordance with §441.505 *individual* means the eligible individual and, if applicable, the individual's representative.

Home and Community-Based Settings (42 CFR 441.530)

Section 1915(k)(1)(A)(ii) of the Act states that CFC services and supports must be provided in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for individuals with intellectual disabilities. Implementing regulations found at 42 CFR 441.530 define and set forth requirements for CFC settings.
The home and community-based settings requirements are designed to establish a more experiential definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The requirements apply to residential settings where individuals reside (irrespective of receiving CFC services in that setting) and non-residential home and community-based settings where CFC services are provided.

Prior to submitting a CFC state plan amendment, under 42 CFR 441.575 (b), states are required to consult and collaborate with a Development and Implementation Council, throughout the development and implementation of the CFC benefit. The requirements related to the Development and Implementation Council are described in a separate section of this letter, below. The state should also review its assessment of compliance with home and community-based settings requirements with the Council prior to SPA submission. This includes the Council's prior review of any intended settings the state intends to submit to CMS for heightened scrutiny review. Additional information on the heightened scrutiny review process is available on www.medicaid.gov/hcbs. CMS also strongly encourages states to seek public input on their processes for assessment of settings. These additional efforts will be of great assistance during the SPA review process in which CMS determines if the settings meet the regulatory requirements.

The first step in CMS's review of a CFC SPA will be the determination that all CFC settings comply with the regulation. Medicaid requirements found at 42 CFR 430.20 specify that a SPA may be approved with an effective date that is retroactive to the first day of the quarter in which an approvable plan is submitted to CMS. However, because a SPA cannot be approved if it would result in the provision of services in non-compliant settings, it may be necessary to amend an effective date of a CFC SPA to coincide with the date settings were determined compliant. Under such circumstances, CMS will work with states to determine the adjusted effective date.

As part of the CFC SPA review process, states must submit adequate information to CMS showing that the settings where individuals receiving CFC services reside or receive CFC services, meet the requirements found at 42 CFR 441.530. To assist states with providing adequate information, states should answer the Standard Review Questions related to Home and Community-Based Settings Criteria for 1915(k) Community First Choice (CFC) SPA submissions. Additionally, CMS has issued guidance to assist states in assessing settings and determining compliance with the regulation[5]. The questions and additional information about the home and community-based settings requirements are included in the attached CFC Technical Guide.

Since the home and community-based settings regulation contains new requirements for settings, CMS expects that states will need to revisit and possibly revise their state regulations or issue sub-regulatory guidance to ensure compliance. Training provided by the states on these new requirements is vital for beneficiaries, their families, case managers, providers, and other stakeholders. States should ensure they have developed strong oversight and quality mechanisms to ensure continued compliance, as well as grievance and appeal systems to address any concerns or potential violations.

[5] www.medicaid.gov/hcbs

The Quality Assurance System (42 CFR 441.585)

The CFC SPA must include a description of a quality assurance system. The system must include a quality improvement strategy that addresses both individual and systemic issues. Among other requirements, the system must also continuously monitor the health and welfare of each CFC recipient, include a process for mandatory reporting, investigation, and resolution of allegations of neglect, abuse or exploitation in connection with CFC services and supports, and a method of measuring individual outcomes associated with an individual's receipt of CFC services. The quality assurance system must include standards for all service delivery models, including how and when an individual can appeal service denials (e.g. type of services requested or the number of assessed service hours), as well as reconsideration procedures for an individual's person-centered service plan. Reconsideration procedures are less formal than the appeals process. They provide the opportunity for the individual receiving CFC services, the individual's representative (if applicable), the person responsible for facilitating the person-centered process and other individuals chosen by the individual to explore an informal resolution to the individual's concerns. With regards to appeals, the fair hearing requirements set forth in part 431, Subpart E, apply to CFC in the same manner as they apply to other Medicaid State plan services. A reconsideration process does not replace the fair hearing process, nor should it delay an individual's right to a fair hearing.

As discussed in our January 16, 2014 regulation, the quality improvement system must also include performance and outcome measures for the home and community setting requirements, In its SPA, the state should include a description of the state's process and content for ongoing monitoring of the compliance for home and community-based settings requirements described in 42 CFR 441.530.

The state's quality assurance system must also include a way to elicit and incorporate feedback from individuals and their representatives, disability organizations, providers, families of people with disabilities or elderly individuals, members of the community and others to improve the quality of the community-based attendant services and supports benefit.

States may consider utilizing existing components of current quality assurance systems used to evaluate other programs to meet this requirement, as long as all of the specific requirements of 42 CFR 441.585 are addressed.

Maintenance of Existing Expenditures (42 CFR 441.570(b)) and Data Collection (42 CFR 441.580)

For the first full twelve month period in which the state plan amendment is implemented, the state must maintain or exceed the level of state expenditures for home and community-based attendant services and supports provided under sections 1115, 1905(a), 1915, or otherwise under the Act, to individuals with disabilities or elderly individuals attributable to the preceding twelve month period.

Additionally, 42 CFR 441.580 specifies the annual data collection requirements for CFC benefits. Guidance on how to meet the maintenance of existing expenditures and the data collection requirements are provided in the attached CFC technical guide.

Concurrent Use of Other Medicaid Authorities with the Section 1915(k) Benefit

1) Managed Care Authorities

Several states have been approved to include CFC as part of a service package available in a managed care arrangement. For a state to receive enhanced FMAP for CFC services, a state plan amendment is still required even when services are provided through a managed care arrangement. States providing CFC services in a managed care arrangement are required to comply with all of 42 CFR 438. Specifically, when a state is including a CFC payment in a health plan capitation rate must include a

separate CFC section in their capitated rate Actuarial Certification that is submitted to the Regional Office. The state must use only CFC services in calculating that portion of the entire capitation payment attributable to CFC in the separate section of the actuarial certification in order to be able to claim expenditures for that portion at the enhanced FMAP under this provision. The required information is outlined in the CFC technical guide. CMS will provide technical assistance to any state interested in adding CFC services to a managed care arrangement.

2) Section 1915(b)(4) Authority

A state may use the section 1915(b)(4) authority to request a waiver of section 1902(a)(23) of the Act, the free choice of providers requirement, to selectively contract with entities that furnish CFC services eligible for the enhanced FMAP.

In order to operate sections 1915(b)/1915(k) concurrently, a state must complete and submit a separate section 1915(b) waiver application and section 1915(k) state plan amendment. Both applications are subject to a 90-day review period (clock). CMS internally coordinates the review of both applications. Because a 1915(b) waiver must be approved on a prospective basis, we encourage a state to submit a request to operate sections 1915(b)/1915(k) concurrently at least six months in advance of the proposed CFC effective date to facilitate a smooth implementation.

3) Section 1115 Medicaid Demonstration Authority

States may make CFC services available to individuals enrolled in an 1115 Medicaid demonstration. As required by section 1915(k)(1) of the Act, to receive the enhanced FMAP associated with the provision of CFC services, the state must have an approved CFC state plan amendment and the individuals must meet all of the CFC program requirements described in 42 CFR 441.510, including meeting eligibility requirements under the state plan. CMS has provided states authority through Section 1115 demonstrations to extend Medicaid eligibility to individuals not otherwise eligible under the state plan. In these cases, states provide a "CFC –like" benefit package to those individuals; however, states may only claim the normal FMAP rate for the provision of those services.

State flexibility in developing approaches to benefits and service delivery

States have flexibility to design a CFC program. For example, states could design a program that is limited to only mandatory services and one service delivery model (i.e., self-directed model with service budget) as an approach to establishing the program in the state. Over time, the state could add multiple optional services and service delivery models to expand the choices available to beneficiaries. Alternatively, the state could design a program that provides maximum choice at the outset.

Comprehensiveness of Reimbursement Methodologies and Submission of 4.19 B pages

Regulations at 42 CFR 430.10 require the state plan to contain a comprehensive description of the state's Medicaid program, including the methods for reimbursing covered services. Therefore, states must submit corresponding 4.19 B pages to describe reimbursement methodologies for CFC services when submitting a state plan amendment to implement the CFC state plan option.

Incorporating the CFC benefit into a state's current long-term services and supports system

As states contemplate adding CFC services to their LTSS system, it is important to consider the impact on existing components of their state LTSS design. While there is not a requirement that states modify existing authorities to implement CFC, states are required to design their systems in a manner that prevents duplicate payment for the same services and clearly articulates the services and delivery of the program.

CMS is committed to providing technical assistance in this and other aspects of CFC, and strongly urges states to discuss their plans with CMS as early as possible. This will allow the state to obtain technical assistance in determining the types of services that can be delivered within CFC, assessing time frames for desired design decisions and implementation, evaluating options for achieving the outcomes desired by the state in expanding their LTSS design, and ensuring a smooth and seamless transition for recipients of services.

Because some states have chosen to move or modify services from existing 1915(c) HCBS waivers as they add the CFC benefit to their Medicaid state plan, it is critical that states work early and closely with the combined CMS state plan and waiver teams to ensure that the state understands its options and designs a system that is compliant with both state plan and waiver requirements.

Consultation Requirements

Prior to submitting a SPA pre-print to CMS, states must consult and collaborate with a state established Development and Implementation Council when developing and implementing a SPA to provide CFC services and supports. The regulations at 42 CFR 441.575 specifically require the majority of the Development and Implementation Council members be individuals with disabilities, elderly individuals, and their representatives. States may use existing Medicaid advisory committees to serve the purpose of the Development and Implementation Council, as long as the membership and purpose of the committee meet the CFC regulatory requirements.

States with federally recognized Indian Tribes and Indian health care providers must consult with Tribes and solicit advice from Indian health care providers, consistent with their Tribal Consultation SPAs, the transparency regulations at 42 CFR section 431.400 if the state is choosing to implement the program through an 1115 Medicaid demonstration, and Section 8 of the CMS Tribal Consultation Policy.[6] We encourage states to work collaboratively with Tribes and Indian health providers in their state to assure inclusion of providers that have the expertise to address the unique cultural needs of American Indians/ Alaska Natives (AI/ANs) and provide culturally competent care in LTSS settings.

SPA Submission Requirements

States must use the attached SPA pre-print to describe the CFC benefit. States must also submit a reimbursement page (attachment 4.19-B) identifying the payment rates for the CFC activities eligible for claiming at the Federal Medical Assistance Percentage (FMAP). In submitting the plan amendments, States must comply with the public notice requirements of 42 CFR 447.205. Additionally, the CFC benefit may be part of a service package available in a managed care arrangement. For a state to receive enhanced FMAP for CFC services, a state plan amendment is still required even when services are provided through a managed care arrangement.

SPAs may be approved with effective dates retroactive to the first day of the quarter in which they are submitted as long as all regulatory requirements are met. SPAs are subject to the traditional State plan review process. Please submit your SPA electronically to your regional office in order to implement these provisions.

We look forward to working with states to implement this Medicaid state plan option. CMS is available to provide technical assistance to states as they consider making CFC a part of a state's strategy for

[6] https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTribalConsultationPolicy2015.pdf

advancing access to home and community-based services, and hopes that the attached tools are helpful to that end.

If you have any questions, please contact Kirsten Jensen, Director, Division of Benefits and Coverage, Disabled and Elderly Health Programs Group, at 410-786-8146.

Sincerely,

/s/

Vikki Wachino
Director

cc:
National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State Territorial Health Officials

Council of State Governments

National Conference of State Legislatures

Academy Health

APPENDIX 9

Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

June 2012

v1.0

Table of Contents

September 2019

Facesheet

The State of New York requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver. The name of the waiver program is Crisis Services for Individuals with Intellectual and Developmental Disabilities (CSIDD). (List each program name if the waiver authorizes more than one program.).

Type of request. This is:

X an initial request for new waiver. All sections are filled.
___ a request to amend an existing waiver, which modifies Section/Part ____
___ a renewal request
Section A is:
___ replaced in full
___ carried over with no changes
___ changes noted in BOLD.
Section B is:
___ replaced in full
___ changes noted in BOLD.

Effective Dates: This waiver/renewal/amendment is requested for a period of Five years beginning April 1, 2020 and ending March 31, 2025.

State Contact: The State contact person for this waiver is Janet Zachary-Elkind and can be reached by telephone at (518) 473-0919, or fax at (518) 486-2495, or e-mail at janet.zachary-elkind@health.ny.gov. (List for each program) 3

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal (if additional space is needed, please supplement your answer with a Word attachment).

Response: A Tribal Notification was sent out on October 15, 2019 informing the Tribes of the submission of a new 1915(b)(4) waiver application to allow selective contracting for Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD). The draft application was published at the following web site: https://opwdd.ny.gov/ny-start/home/1915b4. No comments were received regarding this waiver action.

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver (if additional space is needed, please supplement your answer with a Word attachment).

Response: New York requests a waiver to selectively contract for Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD), which are Medicaid State Plan Rehabilitative services, directed exclusively toward the treatment of Medicaid eligible individuals with intellectual and/or developmental disabilities (I/DD) having mental health or behavioral health needs. This waiver request includes all dual eligible for whom the service is medically necessary. This application requests a five-year waiver approval for selective contracting for CSIDD providers who will provide the crisis services outlined in the approved State Plan. The estimated number of enrollees, at a given time, projected to be served through the CSIDD service is approximately 1,200-2,000 individuals.

CSIDD services are rehabilitative short-term targeted services for individuals with I/DD ages six (6) and older who have significant behavioral or mental health needs and meet the Medical Necessity criteria for the service. CSIDD services are personalized, high-intensity, time-limited services recommended for individuals who experience frequent hospitalizations, crisis visits, use mobile emergency services, and are at risk of losing placement and/or services. CSIDD services are short-term

tertiary care services designed to help stabilize an individual within their existing care network using behavior support professionals to build skills and de-escalate.

Services are delivered by multi-disciplinary teams who provide clinical consultation and treatment and maintain 24/7 service accessibility throughout the entire course of the individual's treatment. Teams include licensed professionals from appropriate behavioral health disciplines who provide clinical consultation and initial assessment within 2 hours of referral from OPWDD. All elements of the service are conducted by clinical professionals and are under the supervision of licensed Clinical and/or Medical Directors. Once the individual is stabilized, the CSIDD team will discharge that individual from the team's caseload. All CSIDD services are provided for the direct benefit of the individual in accordance with the needs and treatment goals identified in their treatment plan and also for assisting in the individual's recovery.

The State Plan approved payment structure will be utilized for CSIDD. The payments are based upon a tiered rate schedule based on the individual's level of need and the medically necessary level of CSIDD clinical team involvement. All payments to the CSIDD provider are paid through eMedNY, the State's MMIS.

Waiver Services:
Please list all existing State Plan services the State will provide through this selective contracting waiver (if additional space is needed, please supplement your answer with a Word attachment).

Response:
This waiver will allow selective contracting of:

- Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD), which are Medicaid State Plan Rehabilitative services

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   ___X___ 1915(b) (4) - FFS Selective Contracting program

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

a. _____ **Section 1902(a) (1) – Statewideness**
b. _____ **Section 1902(a) (10) (B) - Comparability of Services**
c. ___X___ **Section 1902(a) (23) - Freedom of Choice**
d. _____ **Other Sections of 1902 – (please specify)**

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

___X___ The same as stipulated in the State Plan and HCBS waiver
_____ Is different than stipulated in the State Plan (please describe)

2. **Procurement.** The State will select the contractor in the following manner:

___X___ **Competitive** Procurement
_____ **Open** cooperative procurement
_____ **Sole** source procurement
_____ **Other** (please describe)

C. Restriction of Freedom of Choice

1. **Provider Limitations.**

___X___ Beneficiaries will be limited to a single provider in their service area.
_____ Beneficiaries will be given a choice of providers in their service area.

(NOTE: Please indicate the area(s) of the State where the waiver program will be implemented.

The CSIDD service is provided statewide. There are five designated service areas comprised of one or more counties. Participants are limited to the CSIDD provider that serves their county of residence.

Region	**Counties Served**
Region 1	Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans,

	Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates
Region 2	Broome, Chenango, Delaware, Otsego, Tioga, Tompkins Cayuga, Cortland, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego Clinton, Essex, Franklin, Hamilton, Jefferson, St. Lawrence
Region 3	Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington, Orange, Rockland, Sullivan, Westchester Columbia, Dutchess, Greene, Putnam, Ulster
Region 4	Bronx, Manhattan, Queens
Region 4	Brooklyn and Staten Island
Region 5	Nassau, Suffolk

2. **State Standards.**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents (if additional space is needed, please supplement your answer with a Word attachment).

Response: 1915(b)(4) Waiver service providers are held to the same standards for reimbursement, quality and utilization as other providers of Medicaid State Plan and waiver services, and the standards are consistent with access, quality and efficient provision of covered care and services.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations.** The following populations are included in the waiver:

X Section 1931 Children and Related Populations
X Section 1931 Adults and Related Populations
X Blind/Disabled Adults and Related Populations

__X__ Blind/Disabled Children and Related Populations
__X__ Aged and Related Populations
_____ Foster Care Children
_____ Title XXI CHIP Children
_X_ Other: Individuals otherwise enrolled in the State's 1915(c) OPWDD Comprehensive Waiver and not listed above

2. **Excluded Populations.** The following populations are excluded from participating in the waiver:

_____ Dual Eligibles
_____ Poverty Level Pregnant Women
_____ Individuals with other insurance
_____ Individuals residing in a nursing facility or ICF/MR
_____ Individuals enrolled in a managed care program
_____ Individuals participating in a HCBS Waiver program
_____ American Indians/Alaskan Natives
_____ Special Needs Children (State Defined) Please provide this definition.
_____ Individuals receiving retroactive eligibility
__X__ Other (Please define): Individuals without I/DD and significant behavioral or mental health needs who do not meet the medical necessity for the CSIDD services are excluded from this waiver

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.*, what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment)?

   Response: CSIDD designated provider(s) must have sufficient professional staffing to operate in a given region and the ability to coordinate a network of providers to ensure the provision of services for CSIDD service recipients. Providers must ensure the team includes licensed professionals from appropriate behavioral health disciplines who provide clinical consultation and initial contact within two (2) hours of referral from OPWDD. Services will be provided to all individuals who meet medical necessity criteria for the service and teams will maintain 24/7 service accessibility throughout the entire course of the individual's treatment.

   All referrals for CSIDD services will go through OPWDD's regional office points of contact. OPWDD will monitor point-in-time reports for timeliness of access to assessments and treatment planning, monitor the demand for services, and evaluate the need for additional providers if needed.

   Specifically, OPWDD will ensure that:

   - The assessment is completed by the Clinical Team Leader or Clinical Team Coordinator under the supervision of the Clinical or Medical Director in a timely manner as outlined above (within two (2) hours of referral from OPWDD.)
   - Treatment planning based on clinical assessments is conducted by the Clinical Team Leader or Clinical Team Coordinator, under the supervision of the Clinical and/or Medical Director in a timely manner as outlined above including an individualized clinical crisis plan and treatment plan.
   - Timely accessibility of stabilization services including 24/7 service

accessibility throughout the entire course of the individual's treatment

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion (if additional space is needed, please supplement your answer with a Word attachment).

Response: The State will monitor access and performance and will require providers to have sufficient professional staffing to operate in a region. If needed, the State may add additional providers if demand is sufficient.

The State will oversee all referrals and monitor access and performance standards to ensure service delivery according to OPWDD policies and standards. This includes the timely completion of assessment and outreach (including intake). The State will require contractors to hire additional staff or the State may select additional contractors in a given region if the demand is sufficient. The State will also monitor referrals for individuals not meeting the eligibility criteria or who have other unmet needs. These individuals will be referred for other OPWDD long term supports and services.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

Response: The State worked with an independent contractor to conduct a statewide analysis of need. Each provider team varies in size based on the scope of the region and initial identified demand. To ensure adequate access, the State will work with CSIDD providers to determine if teams are not adequately staffed or if additional providers are needed to meet the needs of beneficiaries.

Based on current census data, an estimated 400,000 (or 2% of the total population) of NYS citizens have Intellectual/developmental disabilities. New York state data indicate that 130,000 or about 1/3 of those citizens with IDD, currently receive OPWDD services. Also, according to NYS data, 37.5% (N=48,000) of the people in the OPWDD also have a psychiatric diagnosis. Based on international prevalence studies and consistent with the state's own experiences, it can be estimated that an additional 82,000 citizens with IDD, not currently in the OPWDD system may also have behavioral health care needs.

New York Medicaid claims data indicates that in 2013 and 2014, 4-5% of individuals (N=4,700) known to OPWDD access emergency room services for psychiatric symptoms annually resulting in a total Medicaid cost of 3 million dollars. With the average cost of an emergency room visit estimated at $2,100.00 per person, the actual emergency room service cost for those that are known to the OPWDD system (n=4,700) is estimated at $9.87 million dollars, which is significantly higher than the 3 million dollars that was billed to Medicaid for these services during this time period.

Over the course of 2013-2014, an average of $33 million dollars, or 30% of expenditures, was spent on emergency ($3 million) and short-term, tertiary acute care services statewide ($30 million).

While only a small percentage were hospitalized, 25% of expenditures overall were on inpatient services provided to 1% of the population. Inpatient stays were significantly longer and more costly than would be expected in the general population of mental health service users. In 2017, there were 1,378 individuals with I/DD admitted to the hospital for 31,725 bed days costing. $28 million. Source: https://opwdd.ny.gov/sites/default/files/documents/LI-System_nalysisFinalReport7-30-15.pdf and https://opwdd.ny.gov/sites/default/files/documents/NYC-System-Analysis-Report_0.pdf

It is estimated that the overall demand for CSIDD services will average between 1,650 and 2,000 individuals served at any point in time.

Estimates of Capacity needed

Region	Counties Served	Projected Point in Time Capacity Necessary	Projected Capacity Necessary over a Fiscal Year
Region 1	Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates	306	325
Region 2	Broome, Chenango, Delaware, Otsego, Tioga, Tompkins Cayuga, Cortland, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego Clinton, Essex, Franklin, Hamilton, Jefferson, St. Lawrence		200
Region 3	Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington Orange, Rockland, Sullivan, Westchester Columbia, Dutchess, Greene, Putnam, Ulster	224	350
Region 4	Bronx, Manhattan, Queens	350	500
Region 4	Brooklyn and Staten Island	253	400
Region 5	Nassau, Suffolk	165	350
	Total projected	1,298	2,075

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program (if additional space is needed, please supplement your answer with a Word attachment).

   Response: Contractors are required to report: 1) utilization data regarding service delivery, 2) assessments and CSIDD Plan completion, and 3) quality benchmarks that are currently under development and include timeliness of intake, training and technical assistance, and successful discharge. OPWDD will track and monitor point-in-time reports for timeliness of beneficiary access as well as ongoing delivery of service elements while the beneficiary is enrolled. OPWDD will monitor demand of the service and evaluate the need to adjust providers in a given region.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective

contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above (if additional space is needed, please supplement your answer with a Word attachment)?

Response:
The utilization standard is that consumers receive medically necessary services in the amount, scope and duration identified on their treatment plan. The review process includes random review of the selected treatment plans. Each selected treatment plan is compared with the assessments and the services billed to Medicaid for the specified time frame. One purpose of this aspect of the review is to determine if services are provided in type, amount and duration as needed and as identified in the treatment plan. If services were not provided as needed and planned, the review team looks for explanation as to why not. If the reason was access to, or availability of, qualified direct service providers, the review team looks for documentation of the steps taken by the CSIDD to address the problem. If the problem has not been resolved at the time of the review, the CSIDD must address the issue in its Plan of Correction (POC).

Through regularly occurring point-in-time required reporting, the State will monitor the services compared to the treatment plan requirements. The State plans to use benchmark standards that are currently under development to evaluate a providers' ability to meet set performance measures. Results will be monitored for deficiencies. Any deficiencies identified will be addressed and monitored to ensure that appropriate remediation is completed.

The State will implement satisfaction surveys for CSIDD service recipients and their families to measure satisfaction with the accessibility and utilization of services once the individual is assigned to a team. The State will review survey feedback to inform the evaluation of the service and provide recommendations for additional need and/or remediations. OPWDD will also utilize documentation and billing standards that are currently under development to monitor and ensure the delivery of all service components as a condition of payment.

The State will specifically monitor the stabilization services to be provided by the CSIDD clinical team compared to the treatment plan. Stabilization includes skills training, medication monitoring, and counseling to assist the individual and family/caregiver with effectively responding to or preventing

identified precursors or triggers that would risk their ability to remain in a natural community location. Stabilization also includes assisting the individual and family members, caregivers or other collateral supports with identifying a potential psychiatric or personal crisis; practicing de-escalation skills; developing strategies to build skills and prevent crises; and seeking other supports to restore stability and functioning.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above (if additional space is needed, please supplement your answer with a Word attachment).

Response: Providers who fall below benchmark utilization standards will be required to submit an action plan for performance improvement. Action plans for performance improvement will be required for any benchmark standard that has been previously noted as a programmatic trend and/or area that continues to lack significant improvement. The State will monitor action plans, provide technical assistance and complete remedial site visits if necessary. If a remedial site visit is warranted, a written summary of the site visit will be issued, including findings and recommendations.

All monitoring of individual cases will be maintained and completed by the CSIDD provider. If there is an indication of non-compliance or deficiency identified in the level of CSIDD clinical team involvement requirements additional information will be requested and reviewed to evaluate fully.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

Response: The State's quality standard is that individuals in the

program at least 3 consecutive months will experience the following:

- The rate of hospitalizations and emergency room visits will decrease over time for individuals once they have joined the program (Post-enrollment emergency room and hospitalization rates will drop compared to Pre-enrollment rates)
- Placements will be stabilized through increase caregiver satisfaction (Post-enrollment caregiver satisfaction rates will increase compared to caregiver satisfaction rates at the point of intake)
- Individuals will improve in assessment scores (using the Aberrant Behavior Checklist (ABC) or its equivalent) on all or some of the following items:
  - Hyperactivity/Noncompliance;
  - Irritability/Agitation; and
  - Lethargy/Social Withdrawal

Through regularly occurring point-in-time reporting, the State will monitor contracted providers using benchmarks and performance and programmatic standards.

ii. Take(s) corrective action if there is a failure to comply.

Response: All providers found to have deficiencies will be required to submit an action plan for performance improvement for review and approval by their respective OPWDD Regional Office point of contact and/or Central Office statewide coordinator. Areas found deficient become a particular focus of future review and analysis of compliance. OPWDD will provide technical assistance as necessary to ensure the CSIDD provider comes into compliance and meets required benchmarks. If a provider fails to comply it may be determined that they no longer meet the requirements to be a qualified provider of the service.

2. Describe the State's contract monitoring process specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

a. Describe how the State will (or if this is a renewal or amendment of an

existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

Response: OPWDD's processes for monitoring the programmatic and performance standards is on-going and comprehensive. Methods include routine data collection, action plans for performance improvement, remedial site visits, satisfaction surveys, and meeting with providers and regional OPWDD designated staff. OPWDD intends to issue guidance and/or administrative directives to all CSIDD providers to address identified concerns and provide clarification on CSIDD service delivery. The provision of regular technical assistance provides additional opportunities for evaluating compliance.

ii. Take(s) corrective action if there is a failure to comply.

Response: All providers found to have deficiencies will be required to submit an action plan for performance improvement for review and approval by their respective OPWDD Regional Office point of contact and/or Central Office statewide coordinator. Areas found deficient become a particular focus of future review and analysis of compliance. OPWDD will provide technical assistance as necessary to ensure the CSIDD provider comes into compliance and meets required benchmarks. If a provider fails to comply it may be determined that they no longer meet the requirements to be a qualified provider of the service.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

Response: The §1915(b)(4) waiver will ensure that each individual served by the CSIDD team has a treatment plan that is coordinated with any other provider providing services including a health home provider developing an LIFE plan. The CSIDD team will work with caregivers to assess the individual and his/her current environment leading to the behavioral health/mental health conditions and

symptoms including inpatient hospitalizations, emergency room visits, and potential loss of placement. The CSIDD team will work with the individuals care team to identify all Stabilization services to be provided to the consumer. Staff must be employees of the CSIDD or on contract to the CSIDD. Therefore, by identifying the CSIDD as the selective contracting program, coordination of care is assured.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

Response: Because of the extensive community engagement that OPWDD conducted prior to developing this program, community partners are eager to refer individuals to this program. The primary referral sources for CSIDD are expected to be:

- OPWDD Health Home Care Manager
- Family Member
- Emergency Department/mobile crisis
- Hospital/ID Center
- Mental Health Practitioner/Behavior Specialist
- Other (OPWDD, school, medical personnel)

Information about CSIDD providers is available on the OPWDD website. In addition, upon referral the OPWDD Regional Office or CSIDD provider shares detailed information about the service prior to voluntary enrollment.

B. Individuals with Special Needs

___X___ The State has special processes in place for persons with special needs (Please provide detail).

Response: CSIDD providers must make arrangements or work with the individual's Health Home Care Management entity to provide interpretation, translation or any other service the participant may require due to special needs. This may be accomplished through a variety of means, including: employing culturally competent bi-lingual staff, resources from the community or other CSIDD providers. CSIDD providers are responsible for promoting and implementing cultural competencies, practices and procedures to ensure that diverse cultures are considered in all aspects of the delivery of the service.

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services (if additional space is needed, please supplement your answer with a Word attachment)

New York's actual expenditures for the prospective years will not exceed projected expenditures for the prospective years; and actual expenditures for the prospective years will be equal to the demand under the Medicaid State Plan. 2,000 individuals are projected to meet medical necessity under the newly approved State Plan and will be served at a cost of approximately $7,000 each. This is less costly than a single hospitalization. There is no historic Medicaid trend factor for this service.

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: 10/1/2019 to 9/30/2020

Trend rate from current expenditures (or historical figures): 2.00 %

Projected pre-waiver cost N/A
Projected Waiver cost $14,526,321
Difference: N/A

Year 2 from: 10/1/2020 to 9/30/2021

Trend rate from current expenditures (or historical figures): 2.00 %

Projected pre-waiver cost N/A
Projected Waiver cost $14,816,847
Difference: N/A

/

Year 3 (if applicable) from: 10/1/2021 to 9/30/2022
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost N/A
Projected Waiver cost $15,113,184
Difference: N/A

Year 4 (if applicable) from: 10/1/2022 to 9/30/2023
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost N/A
Projected Waiver cost $15,415,448
Difference: N/A

Year 5 (if applicable) from: 10/1/2023 to 12/31/2024
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost N/A
Projected Waiver cost $15,723,757
Difference: N/A

APPENDIX 10

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

AUG 3 1 2012

Nirav R. Shah, M.D.
Commissioner
New York Department of Health
Corning Tower
Governor Nelson A. Rockefeller Empire State Plaza
Albany, NY 12237

Dear Dr. Shah:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting your request to amend New York's Medicaid section 1115 Demonstrations, entitled "Partnership Plan" (11-W-00114/2), and "Federal-State Health Reform Partnership (F-SHRP)" (11-W-00234/2). We are approving the amendment to the Demonstrations under the authority of section 1115(a) of the Social Security Act, and the amendment is effective from the date of this letter through the end of the Demonstrations.

This award is a partial response to the letter sent April 13, 2011, by Mr. Jason Helgerson, in which Mr. Helgerson requested several changes to the Partnership Plan and F-SHRP Demonstrations. At this time, CMS is approving the state's request to establish the managed long-term care (MLTC) program under the Demonstrations, which will expand mandatory Medicaid managed care enrollment to dually-eligible individuals over age 21 who receive community-based long-term care services in excess of 120 days and provide dually-eligible individuals age 18 – 21, as well as nursing home eligible non-dual individuals age 18 and older, the option to enroll in the MLTC program. In addition, this amendment permits the state to expand eligibility to ensure continuity of care for individuals who are moving from an institutional long-term care setting to receive community-based long term care services through the managed long-term care program.

We look forward to continuing our discussions with your staff on New York's request to transition the state's Section 1915(c) waiver, the Long-Term Home Health Care Program, into the MLTC program once the necessary Section 1915(c) waiver amendment has been approved.

The CMS approval of the Partnership Plan and F-SHRP amendments is conditioned upon continued compliance with the enclosed sets of Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated Federal involvement in the projects. The award is subject to our receiving your written acknowledgement of the awards and acceptance of these STCs within 30 days of the date of this letter.

Copies of the revised STCs and expenditure authorities are enclosed. The waivers for the Demonstrations are unchanged by this amendment, and remain in force.

Your project officer for this demonstration is Ms. Jessica Schubel. She is available to answer any questions concerning your section 1115 demonstration and this amendment. Ms. Schubel's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3032
Facsimile: (410) 786-5882
E-mail: Jessica.Schubel@cms.hhs.gov

Official communication regarding program matters should be sent simultaneously to Ms. Schubel and to Mr. Michael Melendez, Associate Regional Administrator in our New York Regional Office. Mr. Melendez's contact information is as follows:

Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health
26 Federal Plaza
New York, New York 10278

I am pleased that we were able to reach a satisfactory resolution to your request, and look forward to working with you and your staff as you seek to redesign the New York Medicaid program.

If you have questions regarding the terms of this approval, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group at (410) 786-5647.

Sincerely,

[redacted]

Marilyn Tavenner
Acting Administrator

Enclosures

cc: Cindy Mann, Director, Center for Medicaid and CHIP Services
Victoria Wachino, Director, Children and Adults Health Programs Group
Michael Melendez, ARA, New York Regional Office
Jason Helgerson, Deputy Commissioner, New York Department of Health
Vallencia Lloyd, Office of Health Insurance Programs, New York Department of Health

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00234/2**

TITLE: **Federal-State Health Reform Partnership Medicaid Section 1115 Demonstration**

AWARDEE: **New York State Department of Health**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by New York for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period beginning April 1, 2011 through March 31, 2014, be regarded as expenditures under the State's title XIX plan.

The following expenditure authorities shall enable New York to implement the approved Special Terms and Conditions (STCs) for the Federal-State Health Reform Partnership Medicaid Section 1115 Demonstration. The expenditure authorities authorize New York to claim federal funding as medical assistance for the following demonstration costs.

1. **Twelve-Month Continuous Eligibility Period**. Expenditures for health-care related costs for individuals specified in Table 4 of paragraph 16(c) of the STCs for continued benefits during any periods within a twelve-month eligibility period when these individuals would be found ineligible if subject to redetermination.

2. **Dual-Eligible Appeals.** Expenditures for capitation payments provided to managed care organizations (MCOs) which restrict enrollees' right to pursue a Medicaid grievance, as designated under section 1903(m)(2)(A)(xi) and section 1932(b)(4). MCOs participating in the Partnership Plan will be permitted to restrict a Medicare/Medicaid dual eligible who has voluntarily enrolled in an MCO from pursuing a Medicaid grievance procedure with an MCO, to the extent that the individual has already pursued a Medicare appeal for the same issue.

3. **Medicaid Eligibility Quality Control**. Expenditures that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control (MEQC) findings as long as the State is operating the alternative MEQC program as specified in STC 17.

4. **Facilitated Enrollment Services.** Expenditures for enrollment assistance services provided by organizations that do not meet the requirements of section 1903(b)(4) of the Act, as interpreted by section 438.810(b)(1) and (2). Inasmuch as these services may be rendered by MCOs and therefore included in the MCOs' capitation payments, no expenditures other than these payments may be submitted for FFP.

5. **Designated State Health Programs Funding.** Expenditures for designated state health programs which provide health care services to low-income or uninsured New Yorkers in an amount not to exceed the amount of monies the State expends over the demonstration period on the health system reform activities described in STC 37, except that in no case may expenditures exceed the amount that results in $1.5 billion in federal funding between the period of October 1, 2006 and March 31, 2014.

6. **Demonstration-Eligible Community Long Term Services and Supports Population.** Expenditures for health-care related costs for individuals moved from institutional nursing facility settings to community settings for long term services and supports who would not otherwise be eligible based on income, but whose income does not exceed a more liberal income standard, and who receive services through the managed long term care program under this Demonstration.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: **11-W-00234/2**

TITLE: **Federal-State Health Reform Partnership Medicaid Section 1115 Demonstration**

AWARDEE: **New York State Department of Health**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration April 1, 2011 through March 31, 2014.

The following waivers of State plan requirements shall enable New York to implement the approved Special Terms and Conditions (STCs) for the New York Federal-State Health Reform Partnership Medicaid Section 1115 Demonstration.

1. **Statewideness** **Section 1902(a)(1)**

   To permit the exclusion of some residents of some counties in New York from participation in Mandatory Mainstream Managed Care (MMMC) and Managed Long Term Care (MLTC) under this Demonstration.

2. **Medicaid Eligibility and Quality Control** **Section1902(a)(4)(A)**

   To enable New York to employ a Medicaid Eligibility and Quality Control System (MEQC) which varies from that required by law and regulation. New York is required to receive annual approval from CMS for its alternative MEQC program.

3. **Income Comparability** **Section 1902(a)(17)**

   To enable New York to apply a more liberal income standard for individuals who are deinstitutionalized and receive community-based long term care services through the managed long term care program than for other individuals receiving community-based long term care.

4. **Freedom of Choice** **Section 1902(a)(23)(A)**

   To enable New York to restrict freedom-of-choice of provider for MMMC and MLTC enrollees, to the extent of the services furnished through those programs. Beneficiaries shall retain freedom of choice of family planning providers.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00234/2**

TITLE: **Federal-State Health Reform Partnership Medicaid Section 1115 Demonstration**

AWARDEE: **New York State Department of Health**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New York's Federal-State Health Reform Partnership section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the New York State Department of Health (state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the Demonstration and the state's obligations to CMS during the life of the Demonstration. The STCs are effective April 1, 2011 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration is approved through March 31, 2014.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility, Benefits, and Enrollment; Delivery Systems; Federal-State Health Reform Partnership Activities; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Medicaid Program Savings Measures; Evaluation of the Demonstration; and Schedule of state Deliverables for the Demonstration.

Additionally, three attachments have been included to provide supplementary information and guidance for specific STCs.

II. PROGRAM DESCRIPTION AND OBJECTIVES

This Demonstration had its origins in an earlier demonstration, the Partnership Plan that sought to improve the economy, efficiency, and quality of care by requiring families and children to enroll in managed care entities to receive services. This mandatory managed care is known as Mandatory Mainstream Managed Care (MMMC). The Partnership Plan demonstration is ongoing, but MMMC enrollees in 14 counties are now included instead in this Demonstration. New York also has authority under this Demonstration to expand MMMC to elderly and disabled populations.

In 2004, the state was presented with significant reform opportunities including, the aging of New York's population, the continued shift in care from institutional to outpatient settings, and the quality and efficiency advantages that are available through health information technology. The state created the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) capital grant program in that year to invest an anticipated $1 billion over a four-year period, to effectively reform and reconfigure New York's health care delivery system to achieve improvements in patient care and increased efficiency of operation.

In 2005, the state asked the federal government to partner with its HEAL NY initiative to implement reform projects that would improve the quality of care and result in long-term savings for both the state and federal government. This demonstration was approved for an initial 5-year period beginning October 1, 2006; under that demonstration authority, the state committed to pursue the following reform initiatives:

- **Rightsizing Acute Care Infrastructure**. New York's acute care infrastructure is outdated and oversized, while the facilities are highly leveraged with debt. The inexorable migration of health care services to the outpatient setting has added to the significant excess capacity that exists in the state, estimated at over 19,000 beds. As a result, state law was enacted in 2005 establishing the Commission on Health Care Facilities in the 21st Century (Commission) which is charged with recommending reconfiguration measures, including downsizing, restructuringand/or facility closures. Such measures will reduce future Medicaid inpatient hospital costs.

- **Reforming Long-Term Care.** The growth of non-institutional alternatives for long-term care services such as assisted living, advances in medical technology, overall improvement in the health of potential consumers and caregivers, and increasing preference for less restrictive alternatives is generating less demand for nursing facility services. New York will pursue the rightsizing of its long-term care system; implementation of a locally-based, but state-wide point of entry (POE) system to help ensure appropriate services are rendered to recipients; a home modification program to enable recipients to stay at home; and a tele-home care program to help individuals stay healthy and at home.

- **Improvement in Primary/Ambulatory Care**. As increased emphasis is placed on services rendered in outpatient settings, capacity and quality become of primary importance. Under this Demonstration, New York will address the shortage of primary care services; implement programs to better manage individuals with chronic conditions, and collect quality of care data on outpatient services.

The state used its HEAL NY program to implement these initiatives under the demonstration. The HEAL NY program is jointly administered by the Department of Health and the Dormitory Authority of the State of New York and was implemented in phases over the past 5 years. Since early 2005, the state released 17 separate requests for grant application under HEAL NY, committing a total of $2.37 billion in state funds for these efforts.

In 2012, New York added an initiative to the Demonstration to improve service delivery and coordination of long-term care services and supports for individuals through a managed care model. Under the MLTC program, eligible individuals in need of more than 120 days of community based long-term care are enrolled with managed care providers to receive long-term services and supports, as well as other ancillary services. Additional covered services are available on a fee-for-service basis, to the extent that New York has not exercised its option to include the individual in the MMMC. Enrollment in MLTC may be phased in geographically and by group.

The state's goals, specific to managed long term care (MLTC), are as follows:

- Expanding access to managed long-term care for Medicaid enrollees who are in need of long term services and supports (LTSS);
- Improving patient safety and quality of care for enrollees in MLTC plans;
- Reducing preventable inpatient and nursing home admissions; and
- Improving satisfaction, safety and quality of life.

CMS will continue to monitor these activities to ensure that the Demonstration delivers on the promise of increased efficiency and savings that it has been given.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state agrees that it shall comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in the applicable law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a.To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this Demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration, as necessary, to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   a) If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state shall not be required to submit title XIX State Plan Amendments for changes to any populations made eligible solely through the Demonstration. If an eligible population through the Medicaid state plan is affected by a change to the Demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to the health care reforms

undertaken by this Demonstration, designated state health programs, eligibility, enrollment, benefits, enrollee rights, delivery systems, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process outlined in STC 7 below.

7. **Demonstration Amendment Process:** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change, and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

   a) An explanation of the public process used by the state, consistent with the requirements of STC 14, to reach a decision regarding the requested amendment;

   b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis shall include current "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;

   c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

   d) If applicable, a description of how the evaluation design shall be modified to incorporate the amendment provisions.

8. **Demonstration Phase-Out.** The state may suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.

   a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 4 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

      The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. There must be a 14-day period between CMS approval of the phase-out plan and implementation of phase-out activities.

b) Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan its process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and any community outreach activities.

c) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR sections 431.206, 431.210, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR sections 431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. as discussed in the October 1, 2011, state Health Official Letter #10-008.

d) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

9. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration, subject to adequate notice, (in whole or in part at any time) before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the project. CMS shall promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

10. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS's finding that the state materially failed to comply.

11. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

12. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; implementation of milestones; and reporting on financial and other Demonstration components.

13. **Quality Review of Eligibility.** The state will continue to submit by December 31st of each year an alternate plan for Medicaid Eligibility Quality Control (MEQC) as permitted by federal regulations at 42 CFR 431.812(c).

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the Demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

    In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001, letter or the consultation process in the state's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. section431.408(b)(2)).

    In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities, prior to submission of any demonstration proposal, and/or renewal of this Demonstration (42 C.F.R. section431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **Federal Funds Participation.** No federal matching funds for expenditures for this Demonstration will be provided until the effective date identified in the Demonstration approval letter. No FFP is available for this Demonstration for Medicare Part D drugs.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

The mandatory managed care program operated by New York provides Medicaid state plan benefits through comprehensive managed care organizations to those recipients eligible under the state plan as noted below.

16. **Eligibility.**

    a) **Individuals Eligible under the Medicaid State Plan**. The mandatory and optional Medicaid State plan populations described in Tables 1 and 2 derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as described in these STCs. State plan eligibles are included in the demonstration to assure access to cost-effective high quality care.

    b) **New Mandatory Mainstream Managed Care Enrollment Requirement.**
        i. Under the Partnership Plan Demonstration (11-W-00114/2), the state has the authority to require mandatory mainstream managed care enrollment for any of the beneficiaries described in Table 1, except those that reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates counties. Under this Demonstration, any recipient in the eligibility groups listed in Table 1 who live in those 14 counties will now be required to enroll in managed care plans.

Table 1. Eligibility Groups Affected by County-Specific MMMC Enrollment

State Plan Mandatory and Optional Groups	Eligibility Criteria
Pregnant women and children under age 1	Income up to 200% of the federal poverty level (FPL)
Children ages 1 through 5	Income up to 133% FPL
Children ages 6 through 18	Income up to 100% FPL
Children ages 19-20	Income at or below the monthly income standard (determined annually)
Parents and caretaker relatives	Income at or below the monthly income standard (determined annually)

ii. The state has authority to expand mandatory enrollment in mainstream managed care to all individuals identified in Table 2 (except those otherwise excluded or exempted as outlined in STC 18). When the state intends to expand mandatory mainstream managed care enrollment to additional counties, it must notify CMS 90 days prior to the effective date of the expansion, and submit a revised assessment of the Demonstration's budget neutrality agreement, which reflects the projected impact of the expansion for the remainder of the Demonstration approval period

Table 2. Eligibility Groups Affected by new MMMC Enrollment Requirement

State Plan Mandatory and Optional Groups	Eligibility Criteria
Adults and children (age 0-64) receiving Supplemental Security Income (SSI) payments or otherwise disabled	Income at or below the monthly income standard
Adults (age 65+)	Income at or below the monthly income standard

c) **Managed Long Term Care (MLTC)**. This component provides a limited set of Medicaid state plan benefits, including long-term services and supports through a managed care delivery system, to individuals eligible through the state plan who require more than 120 days of community based long term-care services. Services not provided through the MLTC program are provided on a fee-for-service basis.

i. The state has authority to expand mandatory enrollment into MLTC to all individuals identified in Table 3 (except those otherwise excluded or exempted as outlined in STC 28) with initial mandatory enrollment starting in any county in New York City and then expanding state-wide based on the Enrollment plan as outlined in Attachment G. When the state intends to expand into a new county outside of New York City, it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the Demonstration's budget neutrality agreement along with all other required materials as outlined in STC 32.

Table 3: Managed Long Term Care Program

State Plan Mandatory and Optional Groups	FPL and/or other qualifying criteria	Expenditure and Eligibility Group

		Reporting
Adults age 65 and older	Income at or below SSI level	MLTC Adults 65+
Adults/children age 18 - 64	Income at or below SSI level	MLTC Adults 18 – 64
Adults age 65 and older	Income at or below the monthly income standard, or with spend-down to monthly income standard	MLTC Adults 65+
Adults/children Age 18-64 blind and disabled	Income at or below the monthly income standard, or with spend-down to monthly income standard	MLTC Adults 18 – 64
Age 16 – 64 Medicaid Buy In for Working People with Disabilities	Income up to 250%	MLTC Adults 18 – 64
Parents and caretaker relatives 21-64	Income at or below the monthly income standard, or with spend-down to monthly income standard	MLTC Adults 18 – 64
Children age 18 – 20	Income at or below the monthly income standard or with spend-down	MLTC Adults 18 – 64
Pregnant Women	Income up to 200%	MLTC Adults 18 – 64
Poverty Level Children Age 18 to 20	Income up to 133%	MLTC Adults 18 – 64
Foster Children Age 18 – 20	In foster care on the date of 18th birthday	MLTC Adults 18 – 64

Demonstration Eligible Groups	**FPL and/or other qualifying criteria**	**Expenditure and Eligibility Group Reporting**
Community Long Term Services and Supports Population	Income based on higher income standard to community settings for long-term services and supports pursuant to STC 25	MLTC Adults 18 – 64 MLTC Adults 65 and above

d) **Continuous Eligibility Period**.

i. Effective February 1, 2010, the state is authorized to provide a 12-month continuous eligibility period to the groups of individuals specified in Table 4 who are otherwise eligible under the Medicaid state Plan, regardless of the delivery system through which they receive Medicaid benefits. Once the State begins exercising this authority, each newly eligible individual's 12-month period shall begin at the initial determination of eligibility; for those individuals who are re-determined to be eligible consistent with

Medicaid state plan rules, the 12-month period begins at that point. At each annual eligibility redetermination thereafter, if an individual is re-determined to be eligible under Medicaid state plan rules, the individual is guaranteed a subsequent 12-month continuous eligibility period.

Table 4: Groups Eligible for a 12-Month Continuous Eligibility Period

State Plan Mandatory and Optional Groups	Social Security Act/Code of Federal Regulations Reference
Pregnant women aged 19 or older	• 1902(a)(10)(A)(i)(III) or (IV) and • 1902(a)(10)(A)(ii)(I) and (II)
Children aged 19 or 20	1902(a)(10)(A)(ii)(I) and (II)
Parents or other caretaker relatives aged 19 or older	1902(a)(10)(A)(ii)(I) and (II)
Members of low-income families, except for children up to age 19	1931 and 1925
Disabled children who lose SSI due to a change in the SSI definition of disability	1902(a)(10)(A)(i)(II)
Individuals who meet the income and resource requirements of SSI but are not in receipt of cash	1902(a)(10)(A)(ii)(I)
Medically needy individuals including children under 21, pregnant women, parents/caretaker relatives, the aged, blind, and disabled	Without spend-down under 1902(a)(10)(C)(i)(III) • 42 CFR 435.308 • 42 CFR 435.310 • 42 CFR 435.320 • 42 CFR 435.322 • 42 CFR 435.324
Disabled widows/widowers who lost SSI or state supplements due to Social Security benefit increases in 1984 and who applied for continued Medicaid coverage before 1988	1634(b)

Note: Children under 19 who are eligible at the applicable FPL already receive 12-month continuous eligibility period under the Medicaid state plan.

State Plan Mandatory and Optional Groups	Social Security Act/Code of Federal Regulations Reference
Disabled adult children who lose SSI due to OASDI	1634(c)
Disabled widows and widowers aged 60 through 64 who would be eligible for SSI except for early receipt of social security benefits	1634(d)
Individuals who are ineligible for SSI or optional state supplements because of requirements that do not apply under Medicaid	42 CFR 435.122

Individuals eligible for Medicaid in December 1973 as an essential spouse of an aged, blind, or disabled individual who was receiving cash assistance	42 CFR 435.131
Individuals otherwise eligible for SSI or a state supplement except that the increase in OASDI under Pub. L. 92–336 (July 1, 1972) raised their income over the limit allowed under SSI ("pre-Pickle people")	42 CFR 435.134
Individuals otherwise eligible for SSI or a state supplement, except that OASDI cost-of-living increases received after April 1977 raised their income over the limit allowed under SSI ("Pickle people")	42 CFR 435.135

ii. **Exceptions.** Notwithstanding subparagraph i, if any of the following circumstances occur during an individual's 12-month continuous eligibility period, the individual's Medicaid eligibility shall be terminated:

(1) The individual cannot be located;
(2) The individual is no longer a New York State resident;
(3) The individual requests termination of eligibility;
(4) The individual dies;
(5) The individual fails to provide or cooperate in obtaining a Social Security number if otherwise required;
(6) The individual provided an incorrect or fraudulent Social Security number;
(7) The individual was determined eligible for Medicaid in error;
(8) The individual is receiving treatment in a setting where Medicaid eligibility is not available (e.g. institution for mental disease);
(9) The individual is in receipt of long-term care services;
(10) The individual is receiving care, services, or supplies under a section 1915(c) waiver program;
(11) The individual was previously otherwise qualified for emergency medical assistance benefits only, based on immigration status, but is no longer qualified because the emergency has been resolved;
(12) The individual fails to provide the documentation of citizenship or immigration status required under federal law; or
(13) The individual is incarcerated.

17. **Individuals Moved from Institutional Settings to Community Settings for Long-Term Services and Supports.** Individuals discharged from a nursing facility who enroll into the MLTC program in order to receive community-based long-term services and supports are eligible based on a special income standard. The special income standard will be determined by utilizing the average Housing and Urban Development (HUD) Fair Market Rent (FMR) dollar amounts for each of the seven regions in the state, and, subtracting from that average**,** 30 percent of the Medicaid income level (as calculated for a household of one) that is considered available for housing. The seven regions of the state include: Central Region; Northeastern; Western; Northern Metropolitan; New York City; Long Island; and Rochester.

The state shall work with Nursing Home Administrators, nursing home discharge planning staff,

family members, and the MLTC health plans to identify individuals who may qualify for the housing disregard as they are able to be discharged from a nursing facility back into the community and enrolled into the MLTC program.

In addition, the state will ensure that the MLTC MCOs work with individuals, their families, nursing home administrators, and discharge planners to help plan for the individual's move back into the community, as well as to help plan for the individual's medical care once they have successfully moved into his/her home.

18. **Exclusions and Exemptions from MMMC.** Notwithstanding the eligibility criteria in STC 16(b), certain individuals cannot receive benefits through the MMMC program (i.e. are excluded from participation), while others may request an exemption from receiving benefits through the MMMC program (i.e. may be exempted from participation). Tables 5 and 6 list those individuals either excluded or exempted from MMMC.

Table 5: Individuals Excluded from MMMC

Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities or residents of state certified or voluntary treatment facilities for children and youth
Patients in residential health care facilities (RHCF) at time of enrollment and residents in an RHCF who are classified as permanent
Participants in capitated long-term care demonstration projects
Medicaid-eligible infants living with incarcerated mothers
Individuals with access to comprehensive private health insurance if cost effective
Foster care children in the placement of a voluntary agency
Foster care children in direct care [at the option of the local Department of Social Services (LDSS)]
Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid eligible for less than six months (except for pregnant women)
Individuals receiving long-term care services through long-term home health care programs.
Individuals receiving hospice services (at time of enrollment)
Youth in the care and custody of the commissioner of the Office of Family & Children Services
Individuals eligible for the family planning expansion program
Individuals with a "county of fiscal responsibility" code of 97 ((Individuals residing in a State Office of Mental Health facility)
Individuals with a "county of fiscal responsibility" code of 98 (Individuals in an OPWDD facility or treatment center)
Individuals under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention's breast, cervical, colorectal, and/or prostate early detection program and need treatment for breast, cervical, colorectal, or prostate cancer, and are not otherwise covered under creditable health coverage.
Individuals who are eligible for Medicaid buy-in for the working disabled and must pay a premium
Individuals eligible for Emergency Medicaid.

Table 6: Individuals who may be exempted from MMMC

Individuals eligible for both Medicare/Medicaid (dual-eligibles) *
Individuals with chronic medical conditions who have been under active treatment for at least six months with a sub-specialist who is not a network provider for any Medicaid MCO in the service area or whose request has been approved by the New York State Department of Health Medical Director because of unusually severe chronic care needs. Exemption is limited to six months.
Individuals designated as participating in OPWDD sponsored programs.
Individuals already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO in the service area. Exemption is limited to six months.
Individuals with a developmental or physical disability receiving services through a Medicaid home and community based services (HCBS) waiver authorized under section 1915(c) of the Act.
Residents of alcohol/substance abuse long term residential treatment programs
Native Americans
Individuals who are eligible for the Medicaid buy-in for the working disabled and do not pay a premium
Individuals with a "county of fiscal responsibility code of 98" (OPWDD in MMIS) in counties where program features are approved by the state and operational at the local district level to permit these individuals to voluntarily enroll.

***** These persons may **only** join a qualified Medicaid Advantage Plan

19. **Exclusions and Exemptions from MLTC.** Notwithstanding the eligibility criteria in STC 16, certain individuals cannot receive benefits through the MLTC program (i.e. excluded), while others may request an exemption from receiving benefits through the MLTC program (i.e. exempted). Tables 7 and 8 list those individuals either excluded or exempted from MLTC.

Table 7: Individuals excluded from MLTC.

Residents of psychiatric facilities
Residents of residential health care facilities (RHCF) at time of enrollment
Individuals expected to be Medicaid eligible for less than six months
Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (Individuals residing in a State Office of Mental Health facility)
Individuals with a "county of fiscal responsibility" code of 98 (Individuals in an OPWDD facility or treatment center)
Individuals eligible for the family planning expansion program
Individuals under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention's breast, cervical, colorectal, and/or prostate early detection program and need treatment for breast, cervical, colorectal, or prostate cancer, and are not otherwise covered under creditable health coverage.
Residents of intermediate care facilities for the mentally retarded (ICF/MR)
Individuals who could otherwise reside in an ICF/MR, but choose not to
Residents of alcohol/substance abuse long-term residential treatment programs

Individuals eligible for Emergency Medicaid
Individuals in the Office for People with Developmental Disabilities Home and Community Based Services (OPWDD HCBS) 1915(c) waiver program
Individuals in the following 1915(c) waiver programs: Traumatic Brain Injury (TBI), Nursing Home Transition & Diversion (NHTD), and Long-Term Home Health Care Program (LTHHCP)
Residents of Assisted Living Programs
Individuals in receipt of Limited Licensed Home Care Services
Individuals in the Foster Family Care Demonstration

Table 9: Individuals who may be exempted from MLTC.

Individuals aged 18 – 21 who are nursing home certifiable and/or require more than 120 days of community based long-term care services
Native Americans
Individuals who are eligible for the Medicaid buy-in for the working disabled and are nursing home certifiable
Aliessa, aliens

20. **Terms and Conditions Related to Particular Populations**

a) **MMMC Enrollment of Individuals Living with HIV.** The state is authorized to require individuals living with HIV to receive benefits through MMMC. Once the state begins implementing MMMC enrollment in a particular county, individuals living with HIV will have thirty days in which to select a health plan. If no selection is made, the individual will be auto-assigned to a MCO. Individuals living with HIV who are enrolled in a MCO (voluntarily or by default) may request transfer to an HIV SNP at any time if one or more HIV Special Needs Plans (SNPs) are in operation in the individual's district. Further, transfers between HIV SNPs will be permitted at any time.

b) **Restricted Recipient Programs.** The state may require individuals participating in a restricted recipient program administered under 42 CFR 431.54(e) to enroll in MMMC. Furthermore, MCOs may establish and administer restricted recipient programs, through which they identify individuals that have utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the state, and restrict them for a reasonable period of time to obtain Medicaid services from designated providers only. The state must adhere to the following terms and conditions in this regard.

i. Restricted recipient programs operated by MCOs must adhere to the requirements in 42 CFR 431.54(e)(1) through (3), including the right to a hearing conducted by the state.

ii. The state must require MCOs to report to the state whenever they want to place a new person in a restricted recipient program. The state must maintain summary statistics on the numbers of individuals placed in restricted recipient programs, and the reasons for

those placements, and must provide the information to CMS upon request.

c.) **Managed care enrollment of individuals using long term services and supports for both MMMC and MLTC.** The state is authorized to require certain individuals using long-term services and supports to enroll in either mainstream managed care or managed long-term care as identified in STC 16. In addition, the populations that are exempted from mandatory enrollment, based on the exemption lists in STCs 18 and 19 may also elect to enroll in managed care plans. Once these individuals begin to enroll in managed care, the state will be required to provide the following protections for the population:

i. **Person-Centered Service planning** – The state, through its contracts with their MCOs and/or PIHPs, will require that all individuals utilizing long-term services and supports will have a person-centered individual service plan maintained at the MCO or Prepaid Inpatient Health Plan(PIHP). Person-Centered Planning includes consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level, and support systems.

1. The state must establish minimum guidelines regarding the Person-Centered Plan (PCP) that will be reflected in MCO/PIHP contracts. These must include at a minimum, a description of:
    a. The qualification for individuals who will develop the PCP;
    b. Types of assessments;
    c. How enrollees are informed of the services available to them; and
    d. The MCOs' responsibilities for implementing and monitoring the PCP.
2. The MCO/PIHP contract shall require the use of a person centered and directed planning process intended to identify the strengths, capacities, and preferences of the enrollee, as well as to identify an enrollee's long-term care needs and the resources available to meet those needs, and to provide access to additional care options as specified by the contract. The PCPis developed by the participant with the assistance of the MCO/PIHP, provider, and those individuals the participant chooses to include. The plan includes the services and supports that the participant needs.
3. The MCO/PIHP contract shall require that service plans must address all enrollees' assessed needs (including health and safety risk factors) and personal goals, taking into account an emphasis on services being delivered in home and community based settings.
4. The MCO/PIHP contract shall require that a process is in place that permits the participants to request a change to the PCPif the participant's circumstances necessitate a change. The MCO contract shall require that all service plans are updated and/or revised at least annually or when warranted by changes in the enrollee's needs.
5. The MCO/PIHP shall ensure that meetings related to the enrollee's PCP will be held at a location, date, and time convenient to the enrollee and his/her invited participants.
6. The MCO/PIHP contract shall require development of a back-up plan to ensure that needed assistance will be provided in the event that the regular services and supports identified in the individual service plan are temporarily unavailable. The

back-up plan may include other individual assistants or services.

7. The MCO/PIHP contract shall require that services be delivered in accordance with the service plan, including the type, scope, amount, and frequency.
8. The MCO/PIHP contract shall require that enrollees receiving long-term services and supports have a choice of provider, where available, which has capacity to serve that individual within the network. The MCO/PIHP must contract with at least two providers in each county in its service area for each covered service in the benefit package, unless the county has an insufficient number of providers licensed, certified, or available in that county.
9. The MCO/PIHP contract shall require policies and procedures for the MCO/PIHP to monitor appropriate implementation of the individual service plans.

ii. **Health and Welfare of Enrollees** – The state, through its contracts with their MCOs/PIHPs, shall ensure a system is in place to identify, address, and seek to prevent instances of abuse, neglect, and exploitation of its enrollees on a continuous basis. This should include provisions such as critical incident monitoring and reporting to the state, investigations of any incident including but not limited to; wrongful death, restraints, or medication errors that resulted in an injury.

iii. **Network of qualified providers** – The provider credentialing criteria described at 42 CFR 438.214 must apply to providers of long-term services and supports. If the MCO's/PIHP's credentialing policies and procedures do not address non-licensed/non-certified providers, the MCO/PIHP shall create alternative mechanisms to ensure the health and safety of its enrollees. To the extent possible, the MCO/PIHP shall incorporate criminal background checks, reviewing abuse registries, as well as any other mechanism the state includes within the MCO/PIHP contract.

d) **MLTC enrollment**. Including the protections afforded individuals in subparagraph (c) of this STC, the following requirements apply to MLTC plan enrollment.

i. **Transition of care period**. Initial transition into MLTC from fee-for-service. Each enrollee who is receiving community based long-term services and supports that qualify for MLTC must continue to receive services under the enrollee's pre-existing service plan for at least 60 days after enrollment, or until a care assessment has been completed by the MCO/PIHP, whichever is later. Any reduction, suspension, denial, or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404 which clearly articulates the enrollee's right to file an appeal (either expedited, if warranted or standard, the right to have authorized service continue pending the appeal and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the appeal. For initial implementation of the auto-assigned population, the plans must submit data for state review on a monthly basis reporting instances when the plan has issued a notice of action that involves a reduction of split shift or live-in services, or when the plan is reducing hours by 25% or more. The plan will also report the number of appeals and fair hearing requested regarding these reductions. The state shall ensure, through its contracts, that if an enrollee is to change from one MCO/PIHP to another, the MCO/PIHPs will communicate with one another to ensure a smooth transition and provide the new MCO/PIHP with the individual's current service plan.

ii. MLTC Eligibility. MLTC plans conduct the initial programmatic eligibility determination for plan enrollment using a standardized assessment tool designated by the state. The following requirements apply to the activities that must be undertaken by an MLTC plan as it assesses applicants for enrollment in the plan.

1. The state shall ensure all individuals requesting long-term services and supports are assessed for MLTC eligibility.
    a. The MCO/PIHP will use the Semi-Annual Assessment of Members (SAAM) tool (or successor tool designated by the state) to determine if the individual meets the eligibility criteria to be enrolled in an MLTC.
    b. In addition to the SAAM tool, the MCO/PIHP may use other assessment tools as appropriate. The state must review and approve all other assessment tools used by the MCO/PIHP.
    c. The state must ensure, through its contracts, that each MCO/PIHP must complete the initial assessment in the individual home of each individual referred to or requesting enrollment in an MLTC plan, within 30 days of that referral or initial contact. MCO/PIHP compliance with this standard shall be reported to CMS in the quarterly reports as required in STC 62.
2. The MCO/PIHP shall complete a re-assessment at least annually, or at another timeframe as specified in the MCO/PIHP contract.
3. The state shall require each MCO/PIHP, through its contract, to report to the enrollment broker the names of all individuals for whom an assessment is completed. If the individual has not been referred by the enrollment broker, the MCO/PIHP shall report the date of initial contact by the individual and the date of the assessment to determine compliance with the 30-day requirement.
    a. The state shall use this information to determine if individuals have been wrongfully determined ineligible.
    b. The state shall review a sample of those assessments at least annually, either through the EQRO or by the state, to verify the correct determination was made.

iii. Marketing Oversight.

1. The state shall require each MCO/PIHPs, through its contract, to meet 42 CFR 438.104 and state marketing guidelines which prohibit cold calls, use of government logos, and other standards.
2. All materials used to market the MCO/PIHP shall be prior approved by the state.
3. The state shall require, through its contract, that each MCO/PIHP provide all individuals who were not referred to the plan by the enrollment broker with information (in a format determined by the state) describing Managed Long-Term Care, a list of available plans, and information about how to reach the enrollment broker for questions or other assistance. The plan shall report the number of individuals receiving these materials to the state on a quarterly basis pursuant to STC 46.

e) **Demonstration Participant Protections.** The state will assure that adults in LTSS in MLTC programs are afforded linkages to adult protective services through all service

entities, including the MCO's/PIHP's. The state will ensure that these linkages are in place before, during, and after the transition to MLTC as applicable.

f) **Non-duplication of Payment.** MLTC Programs will not duplicate services included in an enrollee's Individualized Education Program under the Individuals with Disabilities Education Act, or services provided under the Rehabilitation Act of 1973.

21. **Mandatory Mainstream Managed Care Program Benefits and Cost-Sharing.** Benefits provided through this Demonstration for the mainstream Medicaid managed care program are identical to those in the Medicaid state plan, and are summarized below:

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and federally Qualified Health Center services
Laboratory and X-ray services
Home health services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21only)
Family planning services and supplies
Physicians services, including nurse practitioners and nurse midwife services
Dental services
Physical and occupational therapy
Speech, hearing, and language therapy
Prescription drugs, over-the-counter drugs, and medical supplies
Durable medical equipment including prosthetic and orthotic devices, hearing aids, and prescription shoes
Vision care services including eyeglasses
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
Nursing facility services
Personal care services
Case management services
Hospice care services
TB-related services
Inpatient and outpatient behavioral health services (mental health and chemical dependence services)
Emergency medical services including emergency transportation
Adult day care
Personal Emergency Response Services (PERS)
Renal dialysis
Home and Community Based Services waivers (HCBS)
Care at Home Program (OPWDD)
Non–emergency transportation
Experimental or investigational treatment (covered on a case by case basis)

Service	Co-pay
Non-preferred brand-name prescription drugs	$3
Preferred brand-name prescription drugs	$1
Generic prescription drugs	$1

Notes: One co-pay is charged for each new prescription and each refill.
No co-payment for drugs to treat mental illness (psychotropic) and tuberculosis.

22. **Managed Long-Term Care.** State plan benefits delivered through MCOs or, in certain districts, prepaid inpatient health plans, with the exception of certain services carved out of the MLTC contract and delivered directly by the State on a fee-for-service basis. All MLTC benefits are listed in Attachment A.

23. **Option for Consumer Directed Personal Assistance Program**. Until such time as the consumer directed personal assistance program (CDPAP) is incorporated into the mainstream and MLTC plans, enrollees shall have the option to elect self-direction on a FFS basis under the state plan. Once incorporated into the plan benefit packages, the state shall ensure through its contracts with the MCOs/PIHPs that enrollees are afforded the option to select self-direction and enrollees are informed of CDPAP as a voluntary option to its members. Individuals who select self-direction must have the opportunity to have choice and control over how services are provided and who provides the service.
    a) **Information and Assistance in Support of Participant Direction.** The state/MCO shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option.
    b) **Participant Direction by Representative.** The participant who self-directs the personal care service may appoint a volunteer designated representative, to assist with or perform employer responsibilities, to the extent approved by the participant. Services may be directed by a legal representative of the participant. Consumer-Directed services may be directed by a non-legal representative freely chosen by the participant. A person who serves as a representative of a participant, for the purpose of directing services, cannot serve as a provider of personal attendant services, for that participant.
    c) **Participant Employer Authority.** The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.
        i. **Participant.** The participant (or the participant's representative) provides training, supervision, and oversight to the worker who provides services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law.
        ii. **Decision Making Authorities.** The participants exercise the following decision making authorities: Recruit staff, hire staff , verify staff's ability to perform identified tasks, schedule staff, evaluate staff performance, verify time worked by staff, and approve time sheets, and discharge staff.
    d) **Disenrollment from Self-Direction.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system through the MMMC or MLTC program. To the extent possible, the member shall provide his/her intent

to withdraw from participant direction. A participant may also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the consumer directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant demonstrates the inability to self direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct services, or if there is fraudulent use of funds, such as substantial evidence that a participant has falsified documents related to participant directed services. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO/PIHP must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.

e) **Appeals.** The following actions shall be considered adverse action under both 42 CFR 431 subpart E and 42 CFR 438 subpart F:
   i. A reduction, suspension, or termination of authorized CDPAP services;
   ii. A denial of a request to change CDPAP services

24. **Adding Services to the MMMC and/or MLTC plan benefit package**. At any point in time the state intends to add to either the MMMC or MLTC plan benefit package currently authorized state plan or Demonstration services that have been provided on a FFS basis, the state must provide CMS the following information, with at least 30 days notice prior to the inclusion of the benefit, either in writing or as identified on the agenda for the monthly calls referenced in STC 45:
    a) A description of the benefit being added to the MCO/PIHPs benefit package;
    b) A detailed description of the state's oversight of the MCO/PIHP's readiness to administer the benefit including: readiness and implementation activities, which may include on-site reviews, phone meetings and desk audits reviewing policies and procedures for the new services, data sharing to allow plans to create service plans as appropriate, process to communicate the change to enrollees, MCO/PIHP network development to include providers of that service, and any other activity performed by the state to ensure plan readiness.
    c) Information concerning the changes being made to MMMC and/or MLTC contract provisions and capitation payment rates in accordance with STC 28.

    CMS reserves the right to delay implementation of the benefit transition until such time as appropriate documentation is provided showing evidence of MCO/PIHP readiness. In addition, new services that are not currently authorized under the state plan or demonstration may be added only through approved amendments to the state plan or demonstration.

    CMS will notify the state of concerns within 15 days. If no comments are received, the state may proceed with the scheduled benefit transition.

25. **Expanding MLTC enrollment into a new geographic area**. At any point in time the state is ready to expand mandatory MLTC plan enrollment into a new geographic area, the state must provide CMS notification at least 90 days prior to the expansion, such notification will include:
    a) A list of the counties that will be moving to mandatory enrollment;
    b) A list of MCO/PIHPs with an approved state certificate of authority to operate in those counties demonstrating that enrollees will be afforded choice of plan within the new geographic area;
    c) Confirmation that the MCO/PIHPs in the new geographic area have met the network requirements in STCs 33 and 34 for each MCO/PIHP.

CMS reserves the right to delay implementation of the geographic expansion until such time as notification documentation is provided.

CMS will notify the state of concerns within 15 days. If no comments are received, the state may proceed with the scheduled geographic expansion.

26. **Facilitated Enrollment.** MCO, health care provider, and community-based organization facilitated enrollers will engage in those activities described in 42 CFR 435.904(d)(2), as permitted by 42 CFR 435.904(e)(3)(ii), within the following parameters:

    a) Facilitated enrollers will provide program information to applicants and interested individuals as described in 42 CFR 435.905 (a).

    b) Facilitated enrollers must afford any interested individual the opportunity to apply for Medicaid without delay as required by 42 CFR 435.906.

    c) If an interested individual applies for Medicaid by completing the information required under 42 CFR 435.907(a) and (b) and 42 CFR 435.910(a) and signing a Medicaid application, that application must be transmitted to the local department of social services (LDSS) for determination of eligibility.

    d) The protocols for facilitated enrollment practices between the LDSS and the facilitated enrollers must:
        i. Ensure that choice counseling activities are closely monitored to minimize adverse risk selection; and
        ii. Specify that determinations of Medicaid eligibility are made solely by the LDSS.

V. DELIVERY SYSTEMS

27. **Contracts.** Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers (FQHC) shall continue in force.

    Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

28. **Managed care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of model contract language. The state shall submit any supporting documentation deemed necessary by CMS. The State must provide CMS with a minimum of 45 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the Demonstration, until the contract compliance requirement is met.

29. **Managed Care Benefit Package.** Individuals enrolled in either MMMC or MLTC must receive, from the managed care program, the benefits as identified in STC 21 and Attachment A, as appropriate. As noted in plan readiness and contract requirements, the state must require that, for enrollees in receipt of LTSS, each MCO/PIHP coordinate, as appropriate, needed state plan services that are excluded from the managed care delivery system, but available through a fee for service delivery system, and must also assure coordination with services not included in the established benefit package.

30. **Revision of the State Quality Strategy.** The state must update its Quality Strategy to reflect all managed care plans operating under MMMC and MLTC programs proposed through this Demonstration and submit to CMS for approval within 90 days of approval of the July 2012 amendment. The state must obtain the input of recipients and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment. The state must revise the strategy whenever significant changes are made, including changes through this Demonstration. Pursuant to STC 47, the state must also provide CMS with annual reporting on the implementation and effectiveness of the updated comprehensive Quality strategy, as it impacts the Demonstration.

31. **Required Components of the State Quality Strategy.** The revised Quality Strategy shall meet all the requirements of 42 CFR 438 Subpart D. The quality strategy must include components relating to managed long-term services and supports. The Quality strategy must address the following regarding the population utilizing long-term services and supports: level of care assessments, service planning, and health and welfare of enrollees.

32. **Required Monitoring Activities by State and/or EQRO.** The State's EQR process for the mainstream managed care and MLTC plans shall meet all the requirements of 42 CFR 438 Subpart E. In addition, the state, or its EQRO shall monitor and annually evaluate the MCO/PIHPs performance on specific new requirements under mandatory enrollment of individuals utilizing long-term services and supports. The state shall provide an update of the processes used to monitor the following activities, as well as the outcomes of the monitoring activities within the annual report in STC 47. The new requirements include, but are not limited to the following:
    a) MLTC Plan Eligibility Assessments – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with LTSS meet the MLTC plan eligibility requirements for plan enrollment. The State will also monitor assessments conducted by the plan where individuals are deemed ineligible for enrollment in an MLTC plan.
    b) Service plans – to ensure that MCOs/PIHPs are appropriately creating and implementing service plans based on enrollees' identified needs.
    c) MCO/PIHP credentialing and/or verification policies – to ensure that LTSS services are provided by qualified providers.
    d) Health and welfare of enrollees – to ensure that the MCO/PIHP, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation.

33. **Access to Care, Network Adequacy and Coordination of Care Requirements for Long Term Services and Supports (LTSS).** The state shall set specific requirements for MCO/PIHPs to follow regarding providers of LTSS, consistent with 42 CFR 438 Part D. These requirements shall

be outlined within each MCO/PIHP contract. These standards should take into consideration individuals with special health care needs, out of network requirements if a provider is not available within the specific access standard, ensuring choice of provider with capacity to serve individuals, time/distance standards for providers who do not travel to the individual's home, and physical accessibility of covered services. The MLTC or mainstream managed care plan is not permitted to set these standards.

34. **Demonstrating Network Adequacy**. Annually, each MCO/PIHP must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offer an adequate coverage of benefits, as described in STC 21 and Attachment B for the anticipated number of enrollees in the service area.

    a) The state must verify these assurances by reviewing demographic, utilization, and enrollment data for enrollees in the Demonstration as well as:
        i. The number and types of providers available to provide covered services to the Demonstration population;
        ii. The number of network providers accepting the new Demonstration population; and
        iii. The geographic location of providers and Demonstration populations, as shown through GeoAccess, similar software, or other appropriate methods.

    b) The State must submit the documentation required in subparagraphs i – iii above to CMS with each annual report.

35. **Advisory Committee as required in 42 CFR 438**. For the duration of the Demonstration the state must maintain a managed care advisory group, comprised of individuals and interested parties, appointed pursuant to state law by the Legislature and Governor. To the extent possible, the state will attempt to appoint individuals qualified to speak on behalf of seniors and persons with disabilities who are impacted by the Demonstration's use of managed care, regarding the impact and effective implementation of these changes on individuals receiving LTSS.

36. **Health Services to Native American Populations.** The plan for patient management and coordination of services for Medicaid-eligible Native Americans developed for the Partnership Plan, in consultation with the Indian tribes and/or representatives from the Indian health programs located in participating counties, shall apply to recipients in this Demonstration.

VI. FEDERAL-STATE HEALTH REFORM PARTNERSHIP (F-SHRP) ACTIVITIES

37. **State Expenditures on Health System Reforms**. Between October 1, 2006, and March 31, 2014, the state is eligible to receive no more than $1.5 billion in FFP if it expends up to $3.0 billion over the same period for the health system reform initiatives identified in this paragraph.

    a) These initiatives will include programs that will promote the efficient operation of the State's health care system; consolidate and right-size New York's health care system by reducing excess capacity in the acute care system; shift emphasis in long-term care from institutional-based to community-based settings; expand the use of e-prescribing, electronic medical records, and regional health information organizations; and improve ambulatory and primary care provision.

b) These reform initiatives may include but are not limited to:

i. Reform activities set forth in (a) above and consistent with the goals of HEAL NY
ii. State Office on Aging programs – Expanded In-Home Services to the Elderly
iii. Office of Mental Health programs –
    A. Community Support Services and Residential Services Program
    B. New York University Child Studies Center
iv. Office of Alcoholism and Substance Abuse Services – Prevention and Treatment Program

c) Additional state-only health care reform investments or changes in the listed uses will be considered an amendment to the Demonstration and processed in accordance with Section III, STC 6.

38. **Federal Financial Participation for Designated State Health Programs (DSHP)**.

a) **Demonstration Approval Period.** Federal Financial Participation (FFP) will be available beginning April 1, 2011, for state expenditures on the DSHP described in STC 39 incurred by the state during the demonstration approval period subject to the limitations outlined below.

i. FFP Cap. FFP for DSHP is limited to the amount of monies the State expends over the demonstration period on the health system reform activities described in STC 37 multiplied by the state's FMAP rate over the same period, except that in no case may FFP be claimed in excess of $1.5 billion between the period of October 1, 2006, and March 31, 2014. For purposes of meeting the requirements for FFP outlined in STC 24, the State's health system reform initiatives will be counted differently during the following time periods:
    (1) For the period beginning October 1, 2006, and ending March 31, 2011, the state's regular FMAP rate of 50 percent will apply; and
    (2) For the period beginning April 1, 2011, and ending March 31, 2014, the state's FMAP rate effective for the quarter in which the expenditures are made will apply.

ii. Timing. The state may not draw federal funds for the programs described in STC 39 until such time as the state makes expenditures for the health system reform initiatives described in STC 37.

iii. Demonstrated Savings. The state must achieve an amount of total Medicaid program savings by the end of the Demonstration period, as calculated under the provisions of Section X.

iv. Reconciliation and Recoupment. If the federal share of these savings are not at least equal to the amount determined under subparagraph (i) the state must return to CMS the amount of federal funds that exceed Medicaid program savings achieved.
    A. As part of the annual report required under Section IV, STC 33, the state will report both DSHP claims and expenditures for health care reforms.

B. The reported claims and expenditures will be reconciled at the end of the Demonstration with the state's MBES submissions.

C. Any repayment required under this subparagraph will be accomplished by the state making an adjustment for its excessive claim for FFP on the CMS-64 by entering an amount in line 10(b) of the Summary sheet equal to the amount by which FFP exceeds Medicaid program savings.

39. **Designated State Health Programs**. Subject to the conditions outlined in STC 38, FFP may be claimed for expenditures made for the following designated state health programs during the demonstration approval period:

a) Health Care Reform Act programs –
   i. Healthy New York
   ii. AIDS Drug Assistance
   iii. Tobacco Use Prevention and Control
   iv. Health Workforce Retraining
   v. Recruitment and Retention of Health Care Workers
   vi. Telemedicine Demonstration
   vii. Pay for Performance Initiatives

b) State Office on Aging programs –
   i. Community Services for the Elderly
   ii. Expanded In-Home Services to the Elderly

c) Office of Mental Health – Community Support Services and Residential Services Program

d) Office for Persons with Developmental Disabilities – Residential and Community Support Services

e) Office of Alcoholism and Substance Abuse Services – Prevention and Treatment Program

f) Office of Children and Family Services - Committees on Special Education direct care programs

g) State Department of Health – Early Intervention Program Services

40. **Designated State Health Programs Claiming Process**

a) Documentation of each designated state health program's expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS.

b) Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the designated state health programs in STC 39. Claims may not be submitted for state expenditures disbursed after the end of the demonstration approval period. The state may draw federal funds only as the state makes disbursements for the health system reform initiatives identified in STC 37.

c) Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any Federal programs are received for the designated state health programs listed in STC 39, they shall not be used as a source of non-federal share.

d) The administrative costs associated with programs in STC 39 and any others subsequently added by amendment to the Demonstration shall not be included in any way as Demonstration and/or other Medicaid expenditures.

e) Any changes to the designated state health programs listed in STC 39 shall be considered an amendment to the Demonstration and processed in accordance with STC 7.

41. **Fraud and Abuse Recoveries.** Medicaid expenditure data for FFY 2005 shows that the state recovers less than one percent of its total Medicaid expenditures.

a) At the end of FFY 2011 (for the period October 1, 2010, through September 30, 2011), the state must demonstrate that its annual level of fraud and abuse recoveries is equal to 1.5 percent of FFY 2005 total computable Medicaid expenditures (or $641 million). CMS will verify compliance with this requirement by reviewing in February 2012 the state-reported fraud and abuse recoveries on the CMS-64, line 9c for FFY 2011.

b) If the state does not meet the targets for FFY 2011, the state will be required to pay the federal government the lesser of:
i. The dollar difference between actual and target recoveries for that year; or
ii. Total claimed FFP for designated state health programs during that year.

c) The federal government will recoup the penalty calculated in item b) above. To accomplish this, the state must make an adjustment for its claims for FFP on the CMS-64 by entering an amount in line 10(b) of the summary sheet equal to the amount of the penalty, divided by the state's FMAP rate. This will ensure that the state's claim of FFP is reduced by the total computable amount calculated in item b) above.

VII. GENERAL REPORTING REQUIREMENTS

42. **General Financial Requirements.** The state must comply with all general financial requirements set forth in section VIII.

43. **Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 CFR 438 et. seq., except as expressly identified as not applicable in the expenditure authorities incorporated into the Demonstration award letter s.

44. **Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality set forth in section IX and the Medicaid Program Savings set forth in section X.

45. **Monthly Calls.** Monthly discussions between CMS and the state regarding this demonstration shall be conducted as part of the monthly calls held for the Partnership Plan Demonstration (11-W-

00114/2). During these calls, the progress of the health care reforms authorized by this Demonstration shall be discussed, as well as any pertinent state legislative developments, and any Demonstration amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the Demonstration. The state and CMS shall jointly develop the agenda for the calls.

46. **Quarterly Reports:** The state must submit progress reports in accordance with the guidelines in Attachment B taking into consideration the requirements in STC 49, no later than 60 days following the end of each quarter (December, March, and June of each Demonstration year). The state may combine the quarterly report due for the quarter ending September with the annual report in STC 47. The intent of these reports is to present the state's analysis and the status of the various operational areas.

47. **Annual Report.** The state must submit an annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The state must submit this report no later than 90 days following the end of each Demonstration year. Additionally, the annual report must include:
    a) A summary of the elements included within each quarterly report;
    b) An update on the progress related to the quality strategy as required in STC 38;
    c) An aggregated enrollment report showing the total number of individuals enrolled in each plan;
    d) A summary of the use of self-directed service delivery options in the state at the time when those benefits are included in the demonstration;
    e) A listing of the new geographic areas the state has expanded MLTC to;
    f) A list of the benefits added to the managed care benefit package;
    g) An updated transition plan, which shows the intended transition and timeline for any new benefits and/or populations into the demonstration;
    h) Network adequacy reporting as required in STC 42;
    i) Any other topics of mutual interest between CMS and the state related to the demonstration; and
    j) Any other information the state believes pertinent to the demonstration.

48. **Transition Plan.** On or before July 1, 2012, and consistent with guidance provided by CMS, the state is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration, including how the state plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must include the required elements and milestones described in paragraphs 48(a)-(e) outline below. In addition, the plan will include a schedule of implementation activities that the state will use to operationalize the Transition Plan. For any elements and milestones that remain under development as of July 1, 2012, the state will include in the Transition Plan a description of the status and anticipated completion date.

    a) **Seamless Transitions.** Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the state plans to obtain and review any additional information needed from each individual to determine eligibility under all

eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act, without interruption in coverage to the maximum extent possible. Specifically, the state must:

i. Determine eligibility under all January 1, 2014, eligibility groups for which the state is required or has opted to provide medical assistance, including the group described in section1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL;
ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014;
iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014, eligibility groups for new applicants for Medicaid eligibility;
iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the state identifies that may be necessary to continue coverage for these individuals; and
v. Develop a modified adjusted gross income (MAGI) calculation for program eligibility.

b) **Access to Care and Provider Payments.**

i. Provider Participation. The state must identify the criteria that will be used for reviewing provider participation in (e.g. demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.
ii. Adequate Provider Supply. The state must provide the process that will be used to assure adequate provider supply for the state plan and Demonstration populations affected by the Demonstration on December 31, 2013. The analysis should address delivery system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of system integration, and other information necessary to determine the current state of the of service delivery. The report must separately address each of the following provider types:
    A. Primary care providers;
    B. Mental health services;
    C. Substance use services; and
    D. Dental services.
iii. Provider Payments. The state will establish and implement the necessary processes for ensuring accurate encounter payments to providers entitled to the prospective payment services (PPS) rate (e.g., certain FQHCs and RHCs) or the all-inclusive rate (e.g., certain Indian Health providers).

c) **System Development or Remediation.** The Transition Plan for the Demonstration is expected to expedite the state's readiness for compliance with the requirements of the Affordable Care Act and other federal legislation. System milestones that must be tested for implementation on or before January 1, 2014, include:

i. Replacing manual administrative controls with automotive processes to support a smooth interface among coverage and delivery system options that is seamless to beneficiaries.

d) **Progress Updates.** After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

e) **Implementation.**

i. By July 1, 2013, the state must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange, or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the state plan, the state will not require these individuals to submit a new application.
ii. On or before December 31, 2013, the state must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

49. **Reporting Requirements Related to Individuals using long term services and supports**.
a) In each quarterly report required by STC 47, the state shall report:
i. Any critical incidents reported within the quarter and the resulting investigations as appropriate;
ii. The number and types of grievances and appeals, filed and/or resolved within the reporting quarter, for this population;
iii. The total number of assessments for enrollment performed by the plans, with the number of individuals who did not qualify to enroll in an MLTC plan;
iv. The number of individuals referred to an MLTC plan that received an assessment within 30 days;
v. The number of people who were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials;
vi. Rebalancing efforts performed by the MLTC Plans and mainstream plans once the benefit is added; Rebalancing reporting should include, but is not limited to the total number of individuals transitioning in and out of a nursing facility within the quarter.
vii. Total number of complaints, grievances and appeals by type of issue with a listing of the top 5 reasons for the event.

VIII. GENERAL FINANCIAL REQUIREMENTS

50. **Quarterly Reports.** The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section IX**.**

51. **Reporting Expenditures Under the Demonstration:** The following describes the reporting of expenditures under the Demonstration:

a) In order to track expenditures under this Demonstration, the state must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All Demonstration expenditures must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made).

b) For monitoring purposes, quarterly cost settlements and pharmaceutical rebates relevant to the Demonstration will be allocated (using an approved methodology) to the Demonstration populations specified in subparagraph (c) and offset against current quarter waiver expenditures. Demonstration expenditures net of these cost settlement offsets will be reported on Form CMS 64.9 Waiver. Amounts offset will be identifiable in the state's supporting work papers and made available to CMS.

c) For each Demonstration year, seven (7) separate waiver Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below, to report expenditures for the following Demonstration populations, as well as for the designated Sstate health programs.

i. **Demonstration Population 1:** TANF Child under age 1 through age 20 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates counties [TANF Child New MC].

ii. **Demonstration Population 2:** TANF Adults aged 21-64 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties [TANF Adult New MC].

iii. **Demonstration Population 3:** Disabled Adults and Children aged 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006 [SSI 0-64 Current MC].

iv. **Demonstration Population 4:** Disabled Adults and Children aged 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 [SSI 0-64 New MC].

v. **Demonstration Population 5:** Aged or Disabled Elderly voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006 [SSI 65+

Current MC].

vi. **Demonstration Population 6:** Aged or Disabled Elderly required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 [SSI 65+ New MC].

vii. **Demonstration Population 7:** MLTC Adults age 18 – 64 [MLTC Adults 18 -64]

viii. **Demonstration Population 8:** MLTC Adults age 65 and above [MLTC Adults 65+]

ix. **Demonstration Expenditures:** Designated State Health Programs [DSHP]

52. **Expenditures Subject to the Budget Neutrality Cap.** For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all Medicaid expenditures on behalf of individuals who are enrolled in this Demonstration and for designated state health program expenditures as described in STC 39. All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures, and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

    All expenditures for managed care enrollment for Demonstration Populations 1 and 2 residing in the counties other than those specified in Section IV, STC 16 who are required to enroll in managed care ("current" mandatory managed care enrollment) will be reported under the Partnership Plan Demonstration (11-W-00114/2). These expenditures may not be reported under this Demonstration.

53. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the Demonstration, subject to the restriction in Section VI, STC 40 (d). All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

54. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the state must continue to identify separately, net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms, in order to properly account for these expenditures in determining budget neutrality.

55. **Reporting Member Months.** The following describes the reporting of member months for Demonstration populations:

    a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 46, the actual number of eligible member months for the Demonstration Populations defined in STC 51 (c) (i-vi). The state must submit a statement accompanying the quarterly report which certifies the

accuracy of this information.

The actual number of member months for current mandatory managed care enrollment for Demonstration Populations 1 and 2 as defined in STC 51 will not be used for the purpose of calculating the budget neutrality expenditure agreement for this Demonstration. They will be used for the budget neutrality expenditure agreement for the Partnership Plan Demonstration (11-W-00114/2).

To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised thereafter as needed.

b) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

c) For the purposes of this Demonstration, the term "Demonstration eligibles" excludes unqualified aliens and refers only to the Demonstration Populations described in STC 51 (c) (i-vi).

56. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The state must estimate matchable Demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

57. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in section IX:

a) Administrative costs, including those associated with the administration of the Demonstration, subject to the restriction in Section VI, STC 40 (d);

b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan.

58. **Sources of Non-Federal Share.** The state certifies that the non-federal share of funds for the Demonstration are state/local monies. The state further certifies that such funds shall not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In

addition, all sources of the non-federal share of funding are subject to CMS approval.

a) CMS shall review the sources of the non-federal share of funding for the Demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b) Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

59. **State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of Demonstration expenditures are met:

a) Units of government, including governmentally-operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the Demonstration.

b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c) To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

60. **Monitoring the Demonstration.** The state will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

IX. MONITORING BUDGET NEUTRALITY

61. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of

approval of the Demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

62. **Risk.** The state shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles under this budget neutrality agreement, but not for the number of Demonstration eligibles in each of the groups. By providing FFP for all Demonstration eligibles, The state shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs for Demonstration eligibles under this agreement, CMS assures that federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

63. **Demonstration Populations Used to Calculate the Budget Neutrality Cap.** The following Demonstration populations are used to calculate the budget neutrality cap and are incorporated into the following eligibility groups (EGs):

a) **Eligibility Group 1:** TANF Child under age 1 through age 20 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates counties (Demonstration Population 1)

b) **Eligibility Group 2:** TANF Adults aged 21-64 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties (Demonstration Population 2)

c) **Eligibility Group 3:** Disabled Adults and Children aged 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 3)

d) **Eligibility Group 4:** Disabled Adults and Children aged 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 4)

e) **Eligibility Group 5:** Aged or Disabled Elderly 65+ voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 5)

f) **Eligibility Group 6:** Aged or Disabled Elderly 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 6)

g) **Eligibility Group 7:** MLTC Adults age 18 – 64 (Demonstration Population 7)

h) **Eligibility Group 8**: MLTC Adults age 65 and above (Demonstration Population 8)

64. **Budget Neutrality Expenditure Cap:** The following describes the method for calculating the budget neutrality expenditure cap for the Demonstration:

a) For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each EG described in STC 63 as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state under STC 55 for each EG, times the appropriate estimated per member per month (PM/PM) costs from the table in subparagraph (ii) below.

ii. The PM/PM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility groups subject to the budget neutrality agreement under this Demonstration are specified below.

For the extension period, the PMPM cost for each EG in Demonstration year 5 outlined below has been increased by the trend rates that were approved for the initial five-year demonstration period, since those trend rates are lower than those included in the President's federal fiscal year 2011 budget.

Eligibility Group	DY 5 (10/1/10 - 3/31/11)	Trend Rate	DY 6 (4/1/11 - 3/31/12)	DY 7 (4/1/12 - 3/31/13)	DY 8 (4/1/13 - 3/31/14)
TANF Children under age 1 through 20	$626	6.7%	$667	$711	$758
TANF Adults aged 21-64	$854	6.6%	$909	$967	$1,029
Disabled Adults and Children aged 0 – 64 voluntarily enrolled in managed care	$2,214	6.12%	$2,349	$2,493	$2,646
Disabled Adults and Children aged 0 – 64 required to enroll in managed care	$2,214	6.12%	$2,349	$2,493	$2,646
Aged or Disabled Elderly 65+ voluntarily enrolled in managed care	$1,389	5.38%	$1,464	$1,542	$1,625
Aged or Disabled Elderly 65+ required to enroll in managed care	$1,389	5.38%	$1,464	$1,542	$1,625
MLTC Adults aged 18 - 64		5.9%		$8,379.01	$8,873.37
MLTC Adults aged 65 and above		3.6%		$7,830.01	$8,111.89

iii. The annual budget neutrality expenditure cap for the Demonstration as a whole is the sum of the projected annual expenditure caps for each EG calculated in subparagraph (i) above.

b) The overall budget neutrality expenditure cap for the demonstration period is the sum of the annual budget neutrality expenditure caps calculated in subparagraph (a) (iii) above for each of the demonstration years. The federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the state may receive for expenditures on behalf of

Demonstration populations and expenditures described in STC 51 (c) during the Demonstration period.

65. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under this demonstration.

66. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis.

67. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period the overall budget neutrality expenditure limit has been exceeded, the excess federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

X. MEDICAID PROGRAM SAVINGS MEASURES

68. **Cumulative Savings Cap.** The State is required to save, through specified health care reform initiatives in Section VI, STC 37, an amount at least equal to the amount of monies the state expends over the demonstration period on the health system reform activities described in STC 37 multiplied by the state's FMAP rate over the same period, this cumulative savings cap is considered a sub cap of the budget neutrality expenditure cap calculated in Section IX.

69. **Demonstration Populations Used to Calculate the Estimated Savings.** The following Demonstration populations are used to calculate the estimated savings and are incorporated into the following EGs:

a) **Eligibility Group 1:** TANF Child under age 1 through age 20 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates counties (Demonstration Population 1)

b) **Eligibility Group 2:** TANF Adults aged 21-64 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties (Demonstration Population 2)

c) **Eligibility Group 4:** Disabled Adults and Children aged 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 4)

d) **Eligibility Group 6:** Aged or Disabled Elderly 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 6)

e) **Eligibility Group 7:** MLTC Adults age 18 – 64 (Demonstration Population 7)

f) **Eligibility Group 8**: MLTC Adults age 65 and above (Demonstration Population 8)

70. **Estimated Medicaid Program Savings As a Subset of the Budget Neutrality Expenditure Cap:** The following describes the method for calculating the estimated Medicaid Program savings cap for the Demonstration:

a) For each year of the budget neutrality agreement an annual Medicaid program savings is calculated for each EG described in STC 68 as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under STC 55 for each EG times the appropriate estimated per member per month (PM/PM) costs from the table in STC 64 (a)(ii).

ii. The annual Medicaid savings cap for the Demonstration, as a whole, is the sum of the projected annual expenditure caps for each EG calculated in subparagraph (i) above minus the actual expenditures for the EGs in STC 69 reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

b) For each year under the Demonstration the amount of savings attributable to hospital rightsizing will be calculated using the following method from the data provided in the annual report required by Section VII, STC 47:

i. (Base Year Medicaid discharges/enrollee – Demonstration Year Medicaid discharges/enrollee) * (Average DY Medicaid costs per discharge) * (Total DY Medicaid enrollees)

c) The overall Medicaid savings cap for the 5-year demonstration period is the sum of the annual Medicaid savings calculated in subparagraph (a) (ii) plus the amount calculated in subparagraph (b) for each of the 5 years. The federal share of the overall Medicaid savings limit represents the maximum amount of FFP that the state may receive.

XI. EVALUATION OF THE DEMONSTRATION

71. **Components.** The demonstration's evaluation shall include a discussion of the goals, objectives, and evaluation questions specific to the purposes of and expenditures made by the state for its health system reform activities. The evaluation must use outcome measures to evaluate the impact of these activities on the efficient operation of the state's health care system during the period of the Demonstration. The outcome measures below represent agreed-upon metrics under which the state and CMS can measure the shared financial benefit of the health care reforms and must be included in the evaluation design:

a) Nursing home admissions - "Value of Averted Medicaid Nursing Home Admissions": For each fiscal year under the demonstration, the number of the reduction in the number of Demonstration Year (DY) Medicaid bed-days below Base Year (BY) level * average cost per bed-day * DY Medicaid enrollees.

b) Reduction in Medicaid debt payment for hospitals - "Value of Avoided Inpatient Debt Payments": For each fiscal year under the demonstration, the reduction in the total inpatient debt per discharge from Base Year (BY) level * Medicaid discharges.

c) Reduction in Medicaid debt payment for nursing homes - "Value of Avoided Nursing Home Debt Payments": For each fiscal year under the demonstration, the reduction in the total nursing facility debt per day from Base Year (BY) level * Medicaid days.

d) The evaluation questions for MLTC goals should include, but are not limited to:
   i. How has enrollment in MLTC plans increased over the length of the demonstration?
   ii. What are the demographic characteristics of the MLTC population? Are they changing over time?
   iii. What are the functional and cognitive deficits of the MLTC population? Are they changing over time?
   iv. Are the statewide and plan-specific overall functional indices decreasing or staying the same over time?
   v. Are the average cognitive and plan-specific attributes decreasing or staying the same over time?
   vi. Are the individual care plans consistent with the functional and cognitive abilities of the enrollees?
   vii. Access to Care: To what extent are enrollees able to receive timely access to personal, home care and other services such as dental care, optometry and audiology?
   viii. Quality of Care: Are enrollees accessing necessary services such as flu shots and dental care?
   ix. Patient Safety: Are enrollees managing their medications? What are the fall rates and how are they changing over time?
   x. Satisfaction: What are the levels of satisfaction with access to, and perceived timeliness and quality of network providers?
   xi. Costs: What are the PMPM costs of the population?

e) The state must submit a revised draft evaluation design to CMS for approval no later than October 1, 2012.

72. **Implementation.** The state must implement the evaluation design and report on its progress in each quarterly report. A final evaluation report is due no later than one year after the expiration of this demonstration.

73. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the Demonstration, the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS.

XII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION

Date - Specific	Deliverable	STC Reference

2/1/2012	Demonstrate Fraud and Abuse Recoveries of $641 million	Section VI, STC 41
10/1/12	Revised Evaluation Design	Section XI, STC 71
3/31/2015	Submit Final Evaluation Report	Section XI, STC 72

	Deliverable	**STC Reference**
Annual	By January 1st - Draft Report	Section VII, STC 48
	By December 31st – MEQC Program Report	Section III, STC 13
Quarterly	Quarterly Operational Reports	Section VII, STC 47
	Quarterly Expenditure Reports	Section VIII, STC 50
	Eligible Member Months	Section VIII, STC 55

Attachment A

Managed Long Term Care Program Benefits

Home Health Care*
Medical Social Services
Adult Day Health Care
Personal Care
Durable Medical Equipment**
Non-emergent Transportation
Podiatry
Dental
Optometry/Eyeglasses
Outpatient Rehabilitation PT, OT, SP
Audiology/Hearing Aids
Respiratory Therapy
Private Duty Nursing
Nutrition
Skilled Nursing Facilities
Social Day Care
Home Delivered/Congregate Meals
Social and Environmental Supports
PERS (Personal Emergency Response Service)

*Home Care including Nursing, Home Health Aide, Physical Therapy (PT), Occupational Therapy (OT), Speech Pathology (SP)

**DME including Medical/Surgical, Hearing Aid Batteries, Prosthetic, Orthotics, and Orthopedic Footwear

ATTACHMENT B

Quarterly Report Guidelines

Under Section VII, STC 47, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook, as well as an updated reform metric workbook. An electronic copy of the report narrative, as well as both Microsoft Excel workbooks is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Federal-State Health Reform Partnership

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 6 (4/1/11 – 3/31/12)
Federal Fiscal Quarter: 4/2011 (7/11 - 9/11)

Introduction: Information describing the goal of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information: Complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0".

Note: Enrollment counts should be person counts for the current quarter only, not participant months.

Population Groups	Current Enrollees	# Voluntary Disenrollments	# Involuntary Disenrollments

ATTACHMENT B

Quarterly Report Guidelines

Population 1 – TANF Child under age 1 through age 20 ("new" MC enrollment)			
Population 2 – TANF Child under age 1 through age 20 ("new" MC enrollment)			
Population 3 – Disabled Adults and Children aged 0-64 ("old" voluntary MC enrollment)			
Population 4 – Disabled Adults and Children aged 0-64 ("new" MC enrollment)			
Population 5 – Aged or Disabled Elderly ("old" voluntary MC enrollment)			
Population 6 – Aged or Disabled Elderly ("new" MC enrollment)			

Voluntary Disenrollments:
Cumulative Number of Voluntary Disenrollments in Current Demonstration Year:
Reasons:

Involuntary Disenrollments:
Cumulative Number of Involuntary Disenrollments in Current Demonstration Year:
Reasons:

Progress of Expansion of Mandatory Managed Care: Summarize progress towards meeting projected enrollment targets

Documentation of Successful Achievement of Milestones (if any during the quarter):
Identify all activities relating to implementation of milestones required under the Demonstration, including but not limited to:

- The activities of the Commission and progress in implementing its recommendations;
- An explanation of grants, contracts or other financial arrangements entered into for purposes of implementing the health system reform efforts of this Demonstration; and
- Any other information pertinent to the health system reform efforts of this Demonstration.

Managed Long Term Care Program: Identify all significant program developments, issues, or problems that have occurred in the current quarter. Additionally, all requirements as outlined in STC 49 should be included.

Consumer Issues: A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback, issues, or concerns received from the MMCARP, advocates, and county officials.

Financial/Budget Neutrality Developments/Issues:

Provide information on:

ATTACHMENT B

Quarterly Report Guidelines

- Health reform expenditures – when and what
- Designated State health programs – amount of FFP claimed for the quarter
- Savings estimates
- Reform metrics

Submit both a completed reform metric workbook and an updated budget neutrality monitoring workbook

Demonstration Evaluation:

Summarize progress on evaluation design, plan, and final report.

Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):

Identify individuals by name, address, title, phone, fax, and email that CMS may contact should any questions arise.

Date Submitted to CMS:

ATTACHMENT C

Managed Long Term Care Program Enrollment Plan

Mandatory Managed Long Term Care/Care Coordination Model

Mandatory Population: Dual eligible, age 21 and over, receiving community based long-term care services for over 120 days, excluding the following:

- **Long-Term Home Health Care Program;**
- **Nursing Home Transition and Diversion waiver participants;**
- **Traumatic Brain Injury waiver participants;**
- **Nursing home residents;**
- **Assisted Living Program participants; and**
- **Dual eligible that do not require community based long-term care services.**

Voluntary Population: Dual eligible, age 18-21, in need of community based long-term care services for over 120 days. Dual eligible age 18-21 and non-dual eligible age 18 and older assessed as nursing home eligible.

The following requires CMS approval to initiate and reflects the enrollment of the mandatory population only.

Phase I: New York City

July 1, 2012 - Any new dual eligible case new to service, fitting the mandatory definition in any New York City county will be identified for enrollment and referred to the Enrollment Broker for action.

- Enrollment Broker will provide with educational material, a list of plans/CCMs, and answer questions and provide assistance contacting a plan if requested.
- Plan/CCM will conduct assessment to determine if eligible for community-based long-term care.
- Plan/CCM transmits enrollment to Enrollment Broker.

In addition, the following identifies the enrollment plan for cases already receiving care. Enrollment will be phased in by service type by borough by zip code in batches. People will be given 60 days to choose a plan according to the following schedule.

July 1, 2012: Begin personal care* cases in New York County

August 1, 2012: Continue personal care cases in New York County

September, 2012: Continue personal care cases in New York County and begin personal care in Bronx County; and begin consumer directed personal assistance program cases in

ATTACHMENT C

Managed Long Term Care Program Enrollment Plan

New York and Bronx counties

October, 2012: Continue personal care and consumer directed personal assistance program cases in New York and Bronx counties and begin Kings County

November, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings counties

December, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties and begin Queens and Richmond counties

January, 2013: Initiate enrollments citywide of Long-Term Home Health Care Program, home health over 120 days, adult day health care program and private duty nursing cases not enrolled under personal care case activity upon CMS approval of 1915(c) waiver amendment.

February, 2013 (and until all people in service are enrolled): Personal care, consumer directed personal assistance program, long term home health care program, home health over 120 days, adult day health care program and private duty nursing cases in New York, Bronx, Kings, Queens and Richmond Counties

*Individuals receiving personal care while enrolled in Medicaid Advantage will begin MLTC/CCM enrollment in January, 2013.

Phase II: Nassau, Suffolk and Westchester Counties

Dually eligible community based long-term care service recipients in these additional counties as capacity is established. Anticipated January 2013

Phase III: Rockland and Orange Counties

Dually eligible community based long-term care service recipients in these additional counties as capacity is established. Anticipated June 2013

Phase IV: Albany, Erie, Onondaga and Monroe Counties

Dually eligible community based long-term care service recipients in these additional counties as capacity is established. Anticipated December 2013

Phase V: Other Counties with capacity

Dually eligible community based long-term care service recipients in these additional counties as

capacity is established. Anticipated June 2014

Phase VI:

Previously excluded dual eligible groups contingent upon development of appropriate programs:

- **Nursing Home Transition and Diversion waiver participants;**
- **Traumatic Brain Injury waiver participants;**
- **Nursing home residents;**
- **Assisted Living Program participants;**
- **Dual eligible that do not require community-based long-term care services.**

APPENDIX 11

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

January 9, 2024

Amir Bassiri
Medicaid Director, Deputy Commissioner
New York Department of Health
Empire State Plaza, Corning Tower, Room 1466
Albany, NY 12237

Dear Amir Bassiri:

The Centers for Medicare & Medicaid Services (CMS) is approving New York's request to amend to its Medicaid section 1115(a) demonstration entitled, "Medicaid Redesign Team" (MRT) (Project Number 11-W-00114/2). Approval of this demonstration amendment will allow the state to advance health equity, reduce health disparities, support the delivery of health-related social needs (HRSN) services, and promote workforce development. In addition, the amendment provides the state with Substance Use Disorder (SUD) demonstration authority. This amendment is effective as of the date of this approval and will remain in effect throughout the demonstration approval period, which is set to expire March 31, 2027.

Through the combination of a Medicaid Hospital Global Budget Initiative, HRSN services and activities, workforce initiatives, and the establishment of a Health Equity Regional Organization (HERO), the state is aiming to reduce health disparities across the state and improve health equity. The New York 1115 demonstration amendment supports the state's interest and preparation in pursuing two Center for Medicare and Medicaid Innovation (CMMI) models—the Making Care Primary model and the States Advancing All-Payer Health Equity Approaches and Development (AHEAD). By the end of this section 1115(a) demonstration, the state's goal is to have made significant movement towards value-based payment (VBP) strategies, multi-payor alignment, and population health accountability. The overall goals of this approval include:

1. Investments in HRSN via greater integration between primary care providers and community-based organizations (CBOs) with a goal of improved quality and health outcomes;
2. Goal of improving quality and outcomes of enrollees in geographic areas that have a longstanding history of health disparities and disengagement from the health system, including through an incentive program for safety net providers with exceptional exposure to enrollees with historically worse health outcomes and HRSN challenges;
3. Focus on integrated primary care, behavioral health (BH), and HRSN with a goal to improve population health and health equity outcomes for high-risk enrollees including kids/youth, pregnant and postpartum individuals, the chronically homeless, and individuals with SUD;

4. Workforce investments with a goal of equitable and sustainable access to care in Medicaid; and
5. Developing regionally focused approaches, including new VBP programs, with a goal of statewide accountability for improving health, outcomes, and equity.

CMS has determined that this amendment is likely to assist in promoting the objectives of the Medicaid statute by increasing access to high-quality medical assistance and coverage for Medicaid beneficiaries. With this amendment, New York is introducing new initiatives and investments to assist the state in improving health coverage, access, and consistent provision of high-quality services for Medicaid beneficiaries, while additionally making important gains in advancing health equity among its beneficiary populations.

As reflected in the statute, the primary objective of the Medicaid program is to furnish medical assistance. This demonstration is expected to promote the objective of furnishing medical assistance by strengthening access to high quality care for all those with Medicaid coverage.

CMS's approval is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to expenditures under the demonstration.

Extent and Scope of the Demonstration Amendment

Approval of the New York amendment includes the following new initiatives: (1) HRSN, (2) HERO, (3) Medicaid Hospital Global Budget Initiative, and (4) Strengthen the Workforce. The initiatives below, in some cases, complement each other to further the demonstration goals. For example, SCNs and the HERO collaborate to ensure standard screening, referral, service delivery, stakeholder engagement, and data collection which is expected to ultimately lead to advanced VBP arrangements and options for incorporating HRSN into VBP methodologies.

(1) HRSN

HRSN Infrastructure

The demonstration amendment provides New York under the HRSN infrastructure authority the opportunity to create SCNs, which are contracted entities in each of the state's regions. The SCNs will provide HRSN screening and referral services to otherwise eligible Medicaid beneficiaries that are targeted populations for HRSN services.

CMS's authorization of limited infrastructure spending up to the amount of $500 million to support HRSN services, is expected to improve the availability and quality of the services delivered.

HRSN Services

CMS is authorizing up to $3.173 billion for the provision of increased coverage of certain services that address HRSN, as evidence indicates that these benefits are critical drivers of an individual's access to health services that keep them well.[1,2] The state has designed a two-tiered system of benefits based on screening. All Medicaid beneficiaries will receive Level 1 services which entails referring individuals to existing state, federal, and local programs that are separate from the newly authorized HRSN set of services. Level 2 HRSN services will be provided to targeted eligible beneficiaries enrolled in Medicaid managed care who meet certain criteria such as: 1) Medicaid high utilizers, 2) individuals enrolled in a New York state designated Health Home, 3) individuals with SUD, 4) individuals with serious mental illness, 5) individuals with intellectual and developmental disabilities, 6) individuals who meet the Department of Housing and Urban Development's definition of homeless, 7) pregnant persons, up to 12 months postpartum, 8) post-release criminal justice-involved population with serious chronic conditions, SUD, or chronic Hepatitis-C, 9) juvenile justice involved youth, foster care youth, and those under kinship care, 10) children under the age of 6, and, 11) children under the age of 18 with one or more chronic conditions. SCNs will work in conjunction with managed care plans to provide referrals for HRSN services.

HRSN services authorized in this demonstration must be evidence-based and medically appropriate for Medicaid eligible beneficiaries who meet predetermined and documented clinical and social risk factors. A comprehensive list of the populations that will be eligible to receive Level 1 and Level 2 HRSN services will be described in the post-approval Protocol(s) for HRSN Services and Infrastructure, subject to CMS review and approval. The specific HRSN services are described in the STCs.

CMS is approving as part of the amendment's HRSN package the potential for individuals with high-risk pregnancies to receive nutrition interventions (i.e., pantry stocking, food prescriptions or meal delivery) for up to the length of the pregnancy, and then up to two months postpartum, for a total of 11 months. These individuals must meet all other requirements to receive the service, including meeting clinical risk factors. This approval also authorizes additional nutritional support (i.e., meals, pantry stocking, food prescriptions) for the households of high-risk pregnant individuals or high-risk children is permitted, if the pregnant individual or child is screened as needing the service. Expanding the nutritional support service to include pantry stocking and food prescriptions in addition to meals treats them similarly and further supports the health needs of the beneficiaries related to social needs. We are defining the size of an eligible household for beneficiaries in alignment with the state's Supplemental Nutrition Assistance Program (SNAP) household definition. These nutritional interventions may be

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[1] As discussed in a letter to State Health Officials issued on January 7, 2021, https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf, addressing Social Determinants of Health can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid program. While "social determinants of health" is a broad term that relates to the health of all people, HRSN relates more specifically to an individual's adverse conditions reflecting needs that are unmet and contribute to poor health. See also https://www.healthaffairs.org/do/10.1377/forefront.20191025.776011/full/

[2] Bachrach, D., Pfister, H., Wallis, K., Lipson, M. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. The Commonwealth Fund; 2014; https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2014_may_1749_bachrach_addressing_patients_social_needs_v2.pdf.

renewed for additional 6-month periods if the state determines the beneficiary still meets the clinical and needs-based criteria. Medicaid-covered HRSN services and supports will not supplant the work or funding of another federal or state non-Medicaid agency. This should include making sure eligible individuals are enrolled in other food assistance programs such as SNAP/WIC as primary and assessment of services provided to make sure that Medicaid is wrapping around and appropriately adjusting Medicaid benefits and not displacing/duplicating these services.

With this approval, CMS will permit up to six months of short-term pre-procedure and post-hospitalization housing, which may be renewed per year (on a rolling 12-month basis) during the approved demonstration period limited to a clinically appropriate time period. Pre-procedure housing has been requested by New York and will focus around an episode of care and preventing use of inpatient or facility services. As indicated above, the totality of the combined services would be six months per 12-month period.

CMS is providing authority for cooking supplies outside of initial transitions into the community, brokerage fees for beneficiaries obtaining housing that requires those payments, as well as transportation costs for beneficiaries accessing covered HRSN and case management services. However, these services are outside of the HRSN capped hypothetical budget neutrality construct and will be paid for with budget neutrality savings by the state.

HRSN services will be provided through a combination of the fee-for-service and managed care delivery systems, with case management and referral services administered through SCNs in each region of the state. The state will initially operationalize the benefits through non-risk arrangements in managed care, effective April 2024, with the aim of integrating the benefits into full risk managed care by March 2027.

CMS also expects the state to maintain existing state funding and efforts for HRSN services, without this demonstration authority supplanting existing efforts, and to have in place partnerships with other state and local entities to coordinate possible pathways to permanency for services to be provided without demonstration authorities.

Coverage of targeted HRSN services and supports is likely to assist in promoting the objectives of Medicaid because it is expected to help beneficiaries stay connected to coverage and access to needed health care. The housing and nutritional support services authorized in the demonstration are expected to stabilize the housing and nutritional situations of eligible Medicaid beneficiaries and thus increase the likelihood that they will keep receiving and benefitting from the Medicaid-covered services to which they are entitled.

Coverage of targeted, clinically appropriate HRSN services will also provide a regular source of care to meet individuals' comprehensive health needs. This is likely to improve health outcomes directly, as well as improve the use of other clinical services. By providing the short-term services needed to stabilize housing, this demonstration will test whether the individual's health outcomes will improve in addition to their utilization of appropriate care.

Moreover, the Medicaid statute, including both sections 1905 and 1915 of the Social Security Act (the Act), already includes mechanisms that reflect the critical role of upstream services (i.e.,

those that help avert more intensive medical interventions) in meeting the medical assistance needs of certain Medicaid-eligible populations (e.g., individuals with disabilities).

Medical assistance made available under a state plan option authorized under section 1915(i) of the Act provides that same package of home and community-based services (HCBS) to individuals meeting needs-based criteria that are less stringent than criteria required for institutional placement. These services are also intended to avert a need for nursing facility care.

Available evidence[3] suggests there may be populations in addition to those eligible under 1915(c) or 1915(i) criteria that would benefit clinically from the section 1915(c) or 1915(i) services described above, as well as additional upstream HRSN services. Additional research is needed to better understand the effects of providing these types of services to a broader group of people. To that end, this demonstration will test whether expanding eligibility for these services to additional populations or providing additional services can improve the health outcomes of certain Medicaid beneficiaries. The demonstration will also test whether extending eligibility for a broader range of Medicaid beneficiaries or providing additional services will help to maintain coverage by preventing health-related incidents that could lead to enrollment churn.[4]

Moreover, access to these services for individuals with poorer health outcomes may help to reduce health disparities. Expanding who can receive these services is expected to help a broader range of Medicaid beneficiaries not only receive, and benefit from, the medical assistance to which they are entitled, but also, these services are expected to further reduce health disparities often rooted in socioeconomic factors.[5] Thus, broadening the availability of certain HRSN services is expected to promote coverage and access to care, improve health outcomes, reduce disparities, and create long-term, cost-effective alternatives or supplements to traditional medical services.

(2) HERO

CMS is authorizing up to $125 million (total computable) in expenditure authority for the HERO over the course of the remaining demonstration period. The HERO is a contracted statewide entity designed to develop regionally focused approaches to reduce health disparities, advance quality and health equity for overall populations, and support the delivery of HRSN services. In support of the demonstration amendment's aim of reducing health disparities, the HERO will conduct the following five activities: (1) data aggregation, analytics, and reporting; (2) conduct a regional needs assessment and planning; (3) convene regional stakeholder engagement sessions; (4) make recommendations to support advanced value-based arrangements and develop options for incorporating HRSN into VBP methodologies; and (5) conduct program analysis, such as publishing initial health equity plans and health factor baseline data on Medicaid populations.

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[3] September 23, 2021. ASPE Contractor Project Report: Building the Evidence Base for Social Determinants of Health Interventions. https://aspe.hhs.gov/reports/building-evidence-base-social-determinants-health-interventions

[4] April 12, 2021. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic. https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

[5] April 1, 2022. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Effort. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

The HERO will assist New York in developing and designing VBP goals to address HRSN and the most impactful health equity priorities.

(3) Medicaid Hospital Global Budget Initiative

CMS is approving this initiative in recognition that some financially distressed safety net hospitals in New York face substantial challenges in making additional, necessary investments for delivery system reform, as they are often already financially hard-pressed to maintain basic operations let alone develop new processes and infrastructure. This initiative will support investments that will lead to measurable improvements in outcomes and financial sustainability of these hospitals which have a high Medicaid and Uninsured Payor Mix. The Medicaid Hospital Global Budget Initiative will support financially distressed safety net hospitals transition to a global budget to incentivize and enable selected hospitals to focus on population health and health equity, improve quality of care, stabilize safety net hospital finances, and advance accountability through the adoption of a global budget alternative payment model.

CMS is authorizing up to $2.2 billion (total computable) over approximately three and a half years (date of amendment approval through March 31, 2027) or $550 million (total computable) annually for the Medicaid Hospital Global Budget Initiative provided that the state meets certain requirements outlined in the STCs. This initiative will provide funding to certain private not-for-profit hospitals that are financially distressed;[6] located in in the Bronx, Kings, Queens, and Westchester Counties due to their significantly adverse health risk factors and health outcomes and Medicaid and Uninsured Payor Mix of at least 45 percent.[7]

In support of the state's delivery system transformation goals, the state will be required to submit a plan for a Medicaid Hospital Global Budget Model. If the state applies for and is chosen as a participant in the CMMI AHEAD model and satisfies criteria as part of its participation in the model, it will be deemed to have met the requirements for this initiative. Nothing binds CMS to approve any future proposal from the state. AHEAD is a voluntary, state-based alternative payment and service delivery model designed to curb health care cost growth, improve population health, and advance quality and health equity by reducing disparities in health outcomes. If the state is not chosen under the AHEAD model, it must submit its own Medicaid Hospital Global Budget Model that meets the requirements specified in the STCs.

(4) Strengthen the Workforce

CMS is authorizing up to $694 million (total computable) over three years to support workforce recruitment and retention to promote the increased availability of certain health care practitioners who serve Medicaid and demonstration beneficiaries. New York, like other states, continues to face health care provider shortages, as well as challenges in recruiting and retaining a diverse

[6] Private Not-For-Profit Hospitals with an average operating margin that is less than or equal to 0 percent over the past four years (Calendar Years 2019-2022) based on audited Hospital Institutional Cost Reports (excluding COVID relief funding and state-only subsidy); and Private Not-For-Profit Hospitals or their affiliates that received state-only subsidies due to financial distress in State Fiscal Years 2023 and/or 2024.

[7] These areas have measurably higher rates of obesity, diabetes, hypertension, congestive heart failure, infant mortality, and avoidable hospitalizations. The Bronx has consistently been ranked as the worst county in New York State with respect to health outcomes and social factors contributing to overall health.

workforce, and the COVID-19 public health emergency (PHE) magnified these issues. This approval continues and builds upon other demonstration workforce initiatives meant to improve access to care for Medicaid beneficiaries. New York will implement two workforce initiatives, Student Loan Repayment for Qualified Providers and Career Pathways Training (CPT), that will target workforce shortages in healthcare staffing, support the delivery of HRSN services, and increase access to culturally appropriate services. Demonstration funding for these initiatives does not supplant state and federal funding or duplicate existing workforce loan repayment and professional training programs.

The student loan repayment program will provide loan repayment for healthcare professionals working in certain healthcare workforce shortage professions,[8] who make a four-year full-time work commitment to a practice panel that includes at least 30 percent Medicaid and/or uninsured members.

The CPT Program is designed to build up the allied health and other healthcare workforce by funding training and education that focuses on career advancement and unemployed individuals in order to create a reliable healthcare workforce pipeline to address health workforce shortages throughout the state. The CPT program will be organized into no more than three regions to support statewide implementation. CPT participation is conditioned on a three-year commitment of service to healthcare providers enrolled in the Medicaid program that serve at least 30 percent Medicaid members and/or uninsured individuals. The state will contract with Workforce Investment Organizations (WIOs), to implement the CPT program. WIOs will provide participant recruitment, coordination of training, supportive services, and meaningful case management support of the individuals to assure successful completion of their programs and job placement.

Designated State Health Programs (DSHP)

In December 2017, CMS issued SMDL #17-005, titled "Phase-out of Expenditure Authority for Designated State Health Programs in Section 1115 Demonstrations," in which CMS announced it no longer would accept state proposals for new or extended section 1115 demonstrations that rely on federal matching funds for DSHP. The 2017 SMD Letter explained that CMS has approved section 1115 demonstrations that provided federal funding for DSHP that had previously been funded only with state funds, because (absent the section 1115 authority) state expenditures on these programs did not qualify for federal matching funds. These approvals enabled the state to use the "freed up" state dollars, that would otherwise have been spent on the DSHP, on demonstration expenditures. CMS has rescinded this previous guidance, effective December 23, 2022,[9] and is implementing an updated approach to DSHP as discussed below and as reflected in other recent section 1115 demonstration approvals.[10]

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[8] The loan repayment amount varies by healthcare professionals and is limited to psychiatrists (up to $300K), primary care physicians (up to $100K), dentists (up to $100K), nurse practitioners (up to $50K), and pediatric clinical nurse specialists (up to $50K).

[9] https://www.hhs.gov/guidance/document/phase-out-expenditure-authority-designated-state-health-programs-section-1115

[10] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-09282022-ca.pdf, and https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ca-10142022.pdf.

Recently, states have proposed demonstrations that seek federal matching funds for a state-funded DSHP so that they can "free up" state funding for Medicaid coverage initiatives. CMS is approving section 1115 demonstrations that provide federal funding for DSHPs under defined criteria that limit both the size and scope of DSHP and apply additional parameters and guardrails. Federal expenditure authority for DSHP is provided only if the state uses the "freed up" state funding on a new demonstration initiative that CMS has determined is likely to assist in promoting the objectives of Medicaid, such as improving access to high-quality covered services. CMS expects that any new DSHP-funded initiative will add to the state's Medicaid program, not supplant existing services or programs.

CMS's revised approach to DSHP, and the approach being approved with this New York MRT amendment, demonstrates CMS's continuing commitment to the federal-state financial partnership as a hallmark of Medicaid. As described in the STCs, New York will be required to contribute state funds other than those freed up by the federal investment in DSHP for expenditures under the DSHP-supported demonstration initiative. DSHP authority will be time-limited, and the state will be required to submit a sustainability plan which describes the scope of DSHP-supported initiatives the state wants to maintain, and the strategy to secure resources to maintain these initiatives beyond the current demonstration approval period.

As described in the STCs, New York is contributing non-DSHP funds (e.g., general revenue) as the non-federal share of the DSHP-supported initiatives on an annual basis. With this New York demonstration amendment, CMS is authorizing up to $3.981 billion in DSHP expenditure authority to support DSHP-Funded Initiatives, which include the HERO, new HRSN services, HRSN infrastructure, and workforce initiatives. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.

As with other recent DSHP approvals, the state can seek federal matching funds up to the amount of the approved DSHP cap only if budget neutrality "savings" are available for that purpose. Because the state will be permitted to use the freed-up state funds that result from approval of the federal matching funds for its DSHP only on initiatives that improve access to covered services, approving the federal match for the state's DSHP is expected to result in an increase in overall service coverage of low-income individuals in the state, improve health outcomes for Medicaid beneficiaries and other low-income populations in the state, and increase efficiency and quality of care. Additionally, because the DSHP-funded HRSN demonstration initiative on which New York is permitted to spend its "freed up" state funds will be treated as "hypothetical" expenditures for purposes of budget neutrality, the state will not be able to generate increased "savings" from the DSHP funded-HRSN demonstration initiative. This will also help to ensure that approving these federal expenditures will not have a significant negative impact on Medicaid fiscal integrity.

The state must contribute $351 million in original, non-freed up DSHP funds, for the remaining demonstration period ending on March 31, 2027, towards its initiatives. Additional requirements for DSHP are defined in the STCs – as are program types excluded from eligibility for DSHP funding – and the state may not claim federal financial participation (FFP) for DSHP until the specific state programs are approved by CMS. CMS has generally not approved DSHP requests for expenditures that are already eligible for federal Medicaid matching funds or other sources of

federal funding, that are generally part of normal operating costs that would be included in provider payment rates, or that are not likely to promote the objectives of Medicaid (e.g., bricks and mortar, animal shelters and vaccines, and revolving capital funds). The specific state programs will be limited to programs that are population- or public health-focused, aligned with the objectives of the Medicaid program with no likelihood that the program will frustrate or impede the primary objective of Medicaid, which is to provide coverage of services for low-income and vulnerable populations, and serve a community largely made up of low-income individuals.

Provider Rate Increase

CMS is committed to improving access to quality care for all Medicaid beneficiaries and is engaged in an "all of Medicaid" approach to improve coverage, access to, and quality of care, as well as to improve health outcomes for all beneficiaries consistent with Medicaid's statutory objectives. Further, we expect that such policies will also have the effect of mitigating health disparities. Research shows that increasing Medicaid payments to providers improves beneficiaries' access to health care services and the quality of care received. To that end, as a condition of approval for expenditure authority for DSHP, quality and health equity initiatives such as the Medicaid Hospital Global Budget Initiative, HRSN services, related infrastructure, Workforce Initiatives, and the HERO, the state will be required to increase and (at least) sustain Medicaid fee-for-service provider base payment rates and Medicaid managed care payment rates in primary care, behavioral health, and obstetrics care, should the state's Medicaid-to-Medicare provider rate ratio dip below 80 percent in any of these categories.

At least a two-percentage point payment rate increase will be applied to each of the services in each service category in each of Medicaid managed care and fee-for-service delivery systems that the state operates. The state must attest that the rate increases will be implemented according to the STCs, and that it will not decrease provider payment rates for other Medicaid or demonstration-covered services for the purpose of making state funds available to finance these required provider rate increases (i.e., cost-shifting). The state must also sustain the increase for the remaining years of the demonstration.

New York is also required to invest approximately $199 million (total computable) in rate increases as part of the demonstration amendment, which must be sustained by the state once implemented. This requirement is applicable even if no Medicaid rates are below 80 percent of Medicare rates. The state may make the rate increases in any demonstration year, but the net provider rate increases must amount to $199,072,125 by the end of the demonstration period. CMS expects the state to prioritize the three core service domains listed above, but the state may invest into specialty rates such as dental services if the three service domains already have rates close to Medicare.

SUD Amendment

On December 21, 2022, New York submitted an amendment application to its section 1115(a) demonstration. With this approval, the state is authorized to receive federal Medicaid matching funds for services delivered to beneficiaries residing in an institution for mental diseases (IMD) with a SUD diagnosis. New York submitted its SUD Implementation Plan and SUD Health

Information Technology (HIT) Plan as required by the STCs. The SUD Implementation Plan describes the strategic approach and detailed project implementation plan, with timetables, programmatic content, and the key goals and objectives of the SUD demonstration. The SUD Implementation Plan also includes a HIT Plan that details the necessary health information technology (IT) capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. CMS has completed its review of the SUD Implementation Plan and SUD HIT Plan and has determined that both are consistent with the applicable requirements set forth in the STCs. The agency is, therefore, concurrently approving the SUD Implementation Plan and SUD HIT Plan. These documents will be incorporated as Attachment H of the STCs.

The goal of the SUD demonstration amendment is for the state to maintain and enhance access to SUD services, and to continue delivery system improvements to provide more coordinated and comprehensive treatment for beneficiaries with SUD. With this approval, beneficiaries will have access to a continuum of services at new settings that, absent this approval, would be ineligible for payment for most Medicaid enrollees. Specifically, the SUD demonstration amendment, in alignment with the demonstration goals outlined in SMDL #17-003, "Strategies to Address the Opioid Epidemic,"[11] published on November 1, 2017, is expected to:

- Increase rates of identification, initiation, and engagement in treatment for SUD;
- Increase adherence to and retention in treatment;
- Reduce overdose deaths, particularly those due to opioids;
- Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
- Reduce readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
- Improve access to care for physical health conditions among beneficiaries with SUD.

Continuous Eligibility for Children

In support of additional coverage expansion across the state, New York has indicated to CMS that it intends to submit an amendment to its demonstration in early 2024 to provide continuous Medicaid eligibility to children up to age six. This policy aims to support consistent coverage and continuity of care by keeping beneficiaries enrolled until they reach age six, regardless of income fluctuations or other changes that otherwise would affect eligibility (except for death or ceasing to be a resident of the state). CMS looks forward to receiving the official amendment request from New York.

Budget Neutrality

Under section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that the demonstration is likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring

[11] https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf.

demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit, and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs). Historically, if a state's "with waiver" (WW) costs for a demonstration approval period were less than the expenditure limit for that period, the unspent funds or "savings" rolled over into the next approval period, which meant that the state could incur higher WW costs during the new approval period.

CMS and states have generally been applying an approach to calculating budget neutrality that CMS described in a 2018 SMDL.[12] Under this approval, projected demonstration expenditures associated with each new Medicaid Eligibility Group in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the approval period. In contrast, under the approach described in the 2018 SMDL, CMS would use the *lower of* the state's historical trend or the President's Budget trend rate. Using the President's Budget trend rate instead aligns the demonstration trend rate with federal budgeting principles and assumptions.

In a key change from the approach described in the 2018 SMDL, CMS is treating certain HRSN expenditures as "hypothetical" for purposes of New York's budget neutrality calculation. As described in the 2018 SMD Letter, when calculating budget neutrality CMS effectively treats a hypothetical expenditure like an expenditure the state could have made absent the demonstration. As a result, hypothetical expenditures are included in both the without waiver (WOW) baseline and the estimate of the with waiver (WW) expenditures under the demonstration, and states do not have to find demonstration "savings" to offset hypothetical expenditures. However, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued "savings" from hypothetical expenditures. That is, "savings" are not generated from a hypothetical population or service if the state does not spend up to the hypothetical expenditure limit. To allow for hypothetical expenditures, while preventing them from resulting in "savings," CMS applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to predetermined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by finding "savings" elsewhere in the demonstration or to refund the federal matching funds to CMS.

In the 2018 SMD Letter, CMS explained that it historically considered demonstration expenditures to be "hypothetical" in the following circumstances: (1) when they are for populations or services that the state could otherwise have covered under its Medicaid state plan or other title XIX authority, such as a waiver under section 1915 of the Act; or (2) when a WOW spending baseline is difficult to estimate due to variable and volatile cost data resulting in

[12] August 22, 2018. SMD#18-009 Re: Budget Neutrality Policies for Section 1115(a) Demonstration Projects. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18009.pdf

anomalous trend rates (e.g., CMS has treated demonstration expenditures on the "adult group" described in section 1902(a)(10)(A)(i)(VIII) of the Act as hypothetical for this reason).

Under this approval, certain HRSN expenditures are considered "hypothetical" expenditures and are included in the budget neutrality WOW baseline. Some of these expenditures, as discussed above, are expenditures for services that the state could otherwise cover under other title XIX authority, such as tenancy and nutrition supports for beneficiaries. Treating those expenditures as hypothetical is consistent with how CMS has historically treated similar expenditures. While other approved HRSN expenditures could not otherwise be covered under title XIX authority, such as expenditures on section 1915(c) and 1915(i) services for beneficiaries who would not otherwise be eligible for them under section 1915, there are insufficient or inconsistent data to calculate a WOW baseline for at least some of these expenditures. Treating those expenditures as hypothetical also is consistent with how CMS has historically treated similar expenditures.

As discussed above, based on robust academic-level research, it appears likely that these state expenditures could improve the quality and effectiveness of downstream services that can be provided under state plan authority.[13] Additionally, as discussed below, covering HRSN services
might improve beneficiary health, reducing the future downstream costs of medical care for these beneficiaries. At the same time, predicting these downstream effects on overall Medicaid program costs of covering certain evidence-based HRSN services is extremely difficult, making it hard for CMS to pinpoint the estimated fiscal impact of these expenditures on demonstration budget neutrality or on the state's overall Medicaid program. Treating demonstration HRSN expenditures as hypothetical will give the state the flexibility to test these worthy innovations, especially as CMS anticipates that they might result in overall reductions in future Medicaid program costs.

Historically, CMS has often authorized expenditures through section 1115 demonstrations subject to expenditure limits. In this case, to ensure that treating certain HRSN expenditures as hypothetical will not have a significant negative impact on Medicaid fiscal program integrity, CMS is applying a budget neutrality spending cap to HRSN services expenditures and an additional sub-cap to HRSN infrastructure expenditures, and is referring to these expenditures as "capped hypothetical expenditures" in the STCs.

The caps on expenditures for these HRSN services and related infrastructure activities differ from the usual limits CMS places on hypothetical expenditures under the "supplemental test" discussed above in several respects. First, ordinarily, if a state exceeds the hypothetical expenditure limit, it can offset the additional costs with savings from the rest of the demonstration. That will not be permitted with the HRSN expenditures. However, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be

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[13] Lipson, D. J. *Medicaid's Role in Improving the Social Determinants of Health: Opportunities for States*. National Academy of Social Insurance; 2017; https://www nasi.org/wp-content/uploads/2017/06/Opportunities-for-States web.pdf; Whitman, A., De Lew, N., Chappel, A., et al. *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*. Assistant Secretary for Planning and Evaluation; 2022; https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOHEvidence-Review.pdf.

applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. Second, the expenditures subject to the cap are narrowly defined to reflect only expenditures associated with services that research indicates are likely to have certain positive downstream effects, as discussed above. Third, the upper limit on the cap is based on a range of estimates of the likely cost of these expenditures over the course of the 3.5 year amendment period and set at a mid-point in that range. While this cap deviates from the traditional approach to hypothetical expenditures, it is consistent with CMS' historical approach to maintaining budget neutrality in Medicaid demonstrations, and it does not alter the underlying financing structure of the Medicaid program. This cap will ensure that the state maintains its investment in the state plan benefits to which beneficiaries are entitled while testing the benefit of the HRSN services described above. This cap will not apply to any other benefits or services.

CMS is also revising the approach to adjusting the budget neutrality calculation in the middle of a demonstration approval period. Historically, CMS has limited its review of state requests for "mid-course" budget neutrality adjustments to situations that necessitate a corrective action plan, in which projected expenditure data indicate a state is likely to exceed its budget neutrality expenditure limit. CMS has updated its approach to mid-course corrections in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (e.g., expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (e.g., unexpected costs due to a public health emergency); or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (e.g., a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

Element of the Request that the State will Pursue via Managed Care Authority

During the course of the negotiations, the state requested to direct its managed care plans to make Medicaid Patient Centered Medical Home (PCMH) payments to align with PCMH payments available to Medicare providers under the Making Care Primary Model. CMCS informed the state that no section 1115 authority was needed for the state to direct its managed care plans to make these payments since primary care is a Medicaid state plan benefit. CMCS apprised the state of alternative options for establishing this model, including a state-directed payment (SDP). CMCS noted other states have established PCMH payments under SDP authority. New York has indicated that it intends to pursue SDP authority for these payments. Nothing binds CMS to approve any future SDP proposal from the state.

Requests Not Being Approved at This Time

New York asked CMS to defer consideration of the serious mental illness (SMI) component of its SUD/SMI amendment until a later time to provide additional time to consider meeting

required milestones under the SMI framework, and to continue discussions with CMS about providing services to individuals who reside in a state mental health hospital or IMD for more than 60 days. Under the 2018 SMI SMDL, the IMD expenditure authority is only available for short-term stays.

New York and CMS continue to review the state's request for limited coverage of certain services furnished to certain incarcerated individuals for up to 90 days immediately prior to the beneficiary's expected date of release. New York is working to align its request with the April 17, 2023 SMDL #23-003, entitled "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated."[14] CMS looks forward to continuing to work with the state on this component of the amendment request.

Monitoring and Evaluation

Consistent with CMS's requirements for section 1115 demonstrations, and as outlined in the demonstration's STCs, the state is required to continue conducting systematic monitoring and robust evaluation of the demonstration, including the policies and initiatives approved through this amendment, per applicable CMS guidance and technical assistance. The demonstration's monitoring activities must support tracking the state's progress toward meeting the goals—including relative to their projected timelines and applicable milestones—of the demonstration's program and policy implementation, and infrastructure investments. The state must report on metrics that relate to the demonstration's key policy components.

The demonstration's metrics reporting must cover categories including, but not limited to, enrollment and renewal, including enrollment duration, access to providers, utilization of services, and quality of care and health outcomes. The state is required to do robust reporting of outcomes of care, cost and quality of care, and access to care aligned with the demonstration's policies and objectives, to be reported for all demonstration populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

To that end, CMS underscores the importance of the state's reporting of quality of care and health outcomes metrics known to be important for closing key equity gaps in Medicaid/ Children's Health Insurance Program (CHIP) (e.g., the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e., social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Disparities-Sensitive Measure Set.

[14] https://www.medicaid.gov/sites/default/files/2023-04/smd23003.pdf

For the HRSN components, in addition to reporting on the metrics described above, the state must track beneficiary HRSN eligibility levels, participation, screening, rescreening, receipt of referrals, recurring nutrition services, and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations, and the contracted providers of applicable services (e.g., managed care plans and their contracted HRSN providers). The state must additionally monitor and provide narrative updates on its progress in building and sustaining its partnership with existing housing and nutrition agencies. Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percent of Medicaid beneficiaries enrolled in other public benefit programs (such as the SNAP or Women, Infants and Children) for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

For the Workforce Initiatives, the state must report on student loan repayment and CPT activities, in addition to providing details on statewide and regional program targets, vacancy rates, CPT program completion rates, and corrective actions. The state must also include narrative information on the operations of the WIOs. For the HERO component, the state must report on data aggregation, regional needs assessments and planning, stakeholder engagement, development of future VBP arrangements, health equity plans, and health factor baseline data. For the Medicaid Hospital Global Budget Initiative, the state must report on the required data and reports outlined in the STCs for each of the demonstration years, as well as data on relevant quality measures and progress toward meeting program targets.

Monitoring Reports should include required financial information (e.g., hospital uncompensated care costs, state-only subsidies received, payor-mix calculations, and operating margin calculations). The state will also be required to provide narrative annually on which hospitals have applied for the CMMI AHEAD model. For the SUD component, the state's monitoring must cover metrics in alignment with the respective milestones as outlined in the SMDL #17-003.

Furthermore, under the STCs and consistent with current CMS guidance, the state must develop a rigorous Evaluation Design using robust data sources and sound analytic approaches that support a comprehensive and meaningful evaluation of the demonstration to assess whether the demonstration components, including components added to the demonstration through this amendment, are effective in producing the desired outcomes for its beneficiaries and providers, as well as the state's overall Medicaid program. In compliance with the STCs, New York submitted to CMS a draft Evaluation Design for the policies effective as of April 2022, which is currently under CMS review. With this amendment approval, the state can choose either to amend its existing draft Evaluation Design or submit a separate Evaluation Design. The demonstration evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components—including those that were authorized in the initial approval of the New York MRT demonstration—that support understanding of the demonstration's impact on beneficiary coverage, access to and quality of care, and health outcomes, as well as its effectiveness in achieving the policy goals and objectives.

In addition to evaluation hypotheses for New York MRT policies that were previously approved, hypotheses for the HRSN components of the demonstration must focus on areas such as beneficiary utilization of HRSN services, severity of beneficiaries' social needs, utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, utilization of hospital and institutional care, and beneficiary physical and mental health outcomes. In addition, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Hypotheses must be designed to help understand the impact of housing supports, case management, nutritional services, and transportation support toward accessing covered HRSN services and case management activities on beneficiary health outcomes and experience.

In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level. The state must also include research questions and hypotheses focused on how renewals of recurring nutrition services affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing, nutrition, and any other type of allowable HRSN services change over time in concert with new Medicaid funding toward those services. In addition, considering how the demonstration's HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. The state is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

For the SUD program, the state must include an assessment of the objectives of these components of the demonstration. Hypotheses may include compliance with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes, such as deaths due to overdose.

The state's evaluation efforts must also develop robust hypotheses and research questions to assess the effectiveness of the state's DSHP-funded initiatives in meeting the desired goals of such programs in advancing and complementing its broader HRSN and other applicable initiatives for its Medicaid beneficiaries and other low-income populations. The analysis must be designed to help demonstrate how these programs support, for example, expanding coverage, improving access, reducing health disparities, and/or enhancing home-and-community-based services or services to address HRSN or behavioral health.

For the Workforce Initiatives, the state must develop hypotheses and research questions to evaluate the effects of the initiatives on beneficiary access to care, as compared to what may be achieved through direct interventions such as rate increases. The state should also evaluate how close estimated costs and positions awarded to each CPT were to actual costs and awards, how effective backfill costs were at retaining work levels while the backfilled individual left for CPT, improvements in overall staffing levels, the rationale for any dropout or incomplete training programs, the quality of the WIO workforce training performance measures, and long-term effects of the workforce programs on retention. The Evaluation Design must outline hypotheses and research questions to assess whether these initiatives sustainably reduce workforce shortages and increase provider retention, especially in the concentration areas such as primary care, behavioral health, and family practice.

The state's evaluation efforts must also include developing hypotheses and research questions to assess the effectiveness of the Medicaid Hospital Global Budget Initiative in ensuring provision of consistent high-quality care to all beneficiaries, as well as progress toward adopting global payment methodologies. Evaluation hypotheses should focus on the effects of the Medicaid Hospital Global Budget Initiative payments toward improving hospital operating margins and an analysis of hospital financial health. For the HERO component of the demonstration, the evaluation should assess the effectiveness of the five main activities: data aggregation, regional needs assessment, stakeholder engagement, designing VBP, and program analysis.

As part of its evaluation efforts, the state must conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. The state must analyze the budgetary effects of the HRSN services, and the overall medical assistance service expenditures and uncompensated care and associated costs for populations eligible for continuous eligibility, including in comparison to populations not eligible for such policies. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

The state is strongly encouraged to evaluate the implementation of the demonstration programs to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. In addition, CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of the various demonstration policy components, and beneficiary experiences with access to and quality of care.

Finally, to the extent feasible, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes

and help inform how the demonstration's various policies might support reducing such disparities.

Consideration of Public Comments

Health Equity Amendment Public Comments

To increase the transparency of demonstration projects, section 1115(d)(1) and (2) of the Act directs the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 demonstration that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary. New York completed its state level public comment period, holding two virtual public hearings, as required, from April 13, 2022, to May 20, 2022.

Section 1115(d)(2)(A) and (C) of the Act further specifies that comment periods should be "sufficient to ensure a meaningful level of public input," but the statute imposes no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline but will not necessarily provide written responses to all public comments (42 Code of Federal Regulations (CFR) 431.416(d)(2)).

The federal comment period opened on September 19, 2022, and closed on October 19, 2022. There were 303 public comments received during the federal comment period; however, nine of these comments were duplicative, unclear, or blank, and, therefore, were not considered. Out of the remaining 294 comments,[15] only one comment expressed opposition to the health equity amendment. Implementation of HRSN services was widely supported within the public comments. The most prevalent common themes in the comments supporting the demonstration were that it promotes equity, addresses social needs, and expands workforce capability. There were 17 comments in support and 276 comments that supported the demonstration but also offered suggestions for improvement.

A single commenter, the nonprofit statewide coalition Health Care For All New York,[16] expressed opposition to the health equity amendment, citing two primary concerns. The first concern was that the demonstration amendment request did not concretely identify the populations targeted or the specific health outcome metrics that would be used to define the demonstration amendment's success. The second concern was that the demonstration's equal allocation of funding across all regions of the state would perpetuate and potentially exacerbate existing racial disparities in New York. The commenter suggested that the funding should be allocated based on the regions with the greatest need.

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[15] Out of the 294 relevant comments, 205 were an identical form letter from pediatric providers.

[16] Health Care for All New York (HCFANY) was the only commenter that overtly opposed the demonstration. HCFANY is a nonprofit that is a statewide coalition of 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers.

Regarding the commenter's concern that the state's application did not concretely identify the populations targeted or identify specific health metrics/ outcomes that would be used to identify the demonstration's success, the demonstration's STCs provide this specificity. For example, the STCs specifically identify the HRSN eligibility criteria for the populations that will receive Level 1 and Level 2 HRSN services. The STCs require the state to monitor and evaluate all components of the demonstration amendment. The monitoring STCs require the state to report on specific metrics for each component of the demonstration amendment. The evaluation STCs require that the state to develop hypotheses and research questions to address every component of the demonstration amendment.

Regarding the comment that the allocation of funding would perpetuate and potentially exacerbate existing racial disparities, the STCs clarify that the amount of HRSN funding is on a statewide basis. Therefore, the areas of the state with the most beneficiaries who qualify for HRSN services will receive the most amount of funding. The stated goal of the amendment is to advance health equity, reduce health disparities, and support the delivery of HRSN services. In addition, the commenter notes that funding should be allocated based on the regions with the greatest need. The Medicaid Hospital Global Budget Initiative is targeted in the areas of the state with the greatest need.

There were 205 identical public comments that were received from a letter writing campaign that supported the amendment, but advocated for additional, dedicated investments in maternal and child health with a focus on improving developmental, behavioral, and mental health. These commenters advocated for the need for the state to meet the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) (child behavior and development) requirements through dedicated funding. In addition, the letter proposed that each region in New York should be required to identify a portfolio of effective behavioral and mental health approaches for children and youth, as outlined in the August 18, 2022, CMCS Informational Bulletin (CIB), that it should implement in demonstration years 2 through 5 of the amendment. Finally, these commenters advocated for continuous enrollment in Medicaid for children up to age six. The state has expressed interest in submitting an additional amendment to pursue continuous enrollment in Medicaid for children up to age six. The state expects to submit this amendment to CMS in early 2024.

Regarding the commenters' recommendation that the state meet EPSDT requirements through dedicated funding, nothing in the New York MRT demonstration overrides any EPSDT requirements. Regarding the commenters' recommendation that New York should be required to identify a portfolio of effective behavioral and mental health approaches for children and youth, the approval of the HRSN services for all children under age 6 and children under the age of 18 with one or more chronic conditions is expected to improve health outcomes for children with behavioral health needs. The August 18, 2022 CIB recommends that states expand provider capacity. The workforce initiatives approved under the demonstration amendment are expected to expand provider capacity in the state.

In addition to the 205 comments received from the letter writing campaign, 14 additional commenters, expressed concern that the amendment would be making insufficient investments in maternal and child health. During the course of the negotiations, the state expressed a desire to increase investments in maternal and child health. As a result, the state broadened the original

HRSN eligibility criteria to include pregnant persons, up to 12 months postpartum, children under age 6, and children under the age of 18 with one or more chronic conditions.

Other commenters recommended that the amendment include more data interoperability and social determinants of health (SDOH) data collection. The STCs require that the HERO conduct data aggregation, analytics, and reporting.

Some commenters shared that there was an insufficient emphasis on nutritional services and housing related services and supports. The HRSN STCs include several nutritional supports such as nutrition counseling, home-delivered meals, medically-tailored or nutritionally-appropriate food prescriptions, and fresh-produce and nonperishable groceries. The HRSN STCs also include several housing related services and supports for specific populations such as recuperative care and short-term pre-procedure and post-hospitalization housing, rent and/or temporary housing, pre-tenancy services, and tenancy-sustaining services.

After carefully reviewing the public comments submitted during the federal comment period and information received from the state public comment period, CMS has concluded that the health equity demonstration amendment is likely to assist in promoting the objectives of Medicaid.

SUD Public Comments

New York completed its state level public comment period for its SUD amendment, holding two virtual public hearings, as required, between October 5, 2022, to November 4, 2022. The federal comment period opened on January 5, 2023, and closed on February 4, 2023. CMS received seven comments during this federal comment period. Two were blank. Of the remaining five comments, two were from the same commenter. Overall, there were four separate commenters. One of the commenters supported the demonstration amendment for furthering efforts to improve behavioral health services and treatment. The other three commenters expressed opposition to the amendment.

One commenter raised concerns about the length of stay in IMDs. Any state with a section 1115 SUD demonstration is expected to meet a statewide average length of stay (ALOS) of 30 days or less in residential treatment settings over the duration of the demonstration approval period. Per the STCs, the state is required to monitor the ALOS in IMDs throughout the course of the demonstration approval period, and in the event the metric trend indicates any risks for the state to not meet the ALOS target over the approval period, it is required to develop careful mitigation strategies in its mid-point assessment.

The three commenters who opposed the demonstration amendment shared concerns that authorizing FFP for services provided in IMDs could risk diverting resources away from community-based services and would undermine community integration efforts for beneficiaries with SUD. Nothing in this demonstration requires that services be provided to any individual in any particular setting, nor does it limit the availability of community-based settings. Further, CMS requires states as part of the SUD demonstration to provide access to care across the continuum of care, including outpatient settings. CMS also requires a utilization review process to ensure beneficiaries receive treatment in the appropriate level of care.

One commenter recommended that CMS and the state ensure that Medication Assisted Treatment (MAT) is available, and that CMS and the state track increased MAT intake among IMD residents with SUD. It is a SUD demonstration milestone that MAT be available in residential treatment settings, and CMS will be tracking MAT availability as part of its demonstration monitoring.

Some of the commenters opined that the state has not explained why obtaining FFP for services in an IMD is a valid experiment under section 1115 of the Act and that CMS lacks authority to approve this amendment. CMS has determined that New York's request serves a research and demonstration purpose, as outlined in SMDL #17-003. Proposed hypotheses outlined in the state's application to be tested through evaluation include that, "Researchers will assess the impact of providing the full continuum of SUD treatment services, particularly residential treatment, on hospital emergency department utilization, inpatient hospital utilization, and readmission rates." CMS will work with the state to further detail evaluation plans as part of the evaluation design process outlined in the STCs.

We note that the demonstration includes both robust monitoring and evaluation requirements, and we expect the demonstration to yield data and analysis useful to Congress, the state, CMS, researchers, and other stakeholders. Furthermore, CMS does not lack the authority to approve the state's request for IMD expenditure authority. Section 1115(a)(2) of the Act grants the Secretary the authority, in the context of a demonstration project under section 1115(a), to provide federal matching for state expenditures that would not otherwise be federally matchable under the terms of section 1903. This "expenditure authority" has been exercised by the Secretary for decades to conduct demonstration projects that provide expanded coverage for individuals or services that could not otherwise be covered under a State's Medicaid State plan. This interpretation has been upheld in Court as a valid exercise of the Secretary's demonstration authority under section 1115. For example, Federal Courts have upheld demonstration projects that covered individuals under section 1115(a)(2) who would not otherwise be eligible for coverage. *See Spry v. Thompson*, 487 F.3d 1272 (9th Cir. 2007); *Wood v. Betlach*, No. CV-12-08098, 2013 WL 3871414 (D. Ariz. July 26, 2013).

After careful review of the public comments submitted during the federal comment period and the information received from the state, including information about comments the state received during the state-level public comment period, CMS has concluded that the SUD demonstration amendment is likely to advance the objectives of Medicaid.

Other Information

The award is subject to CMS receiving written acceptance within 30 days of the date of this approval letter. Your project officer is Jonathan Morancy and he is available to answer any questions concerning this amendment and his contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-25-26
7500 Security Boulevard

Baltimore, Maryland 21244-1850
Email: Jonathan.Morancy@cms.hhs.gov

We appreciate the state's commitment to improving the health of its Medicaid beneficiaries, and we look forward to our continued partnership on the New York MRT section 1115(a) demonstration. If you have any questions regarding this approval, please contact Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

[redacted]

Daniel Tsai
Deputy Administrator and Director

Enclosure

cc: Melvina Harrison, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITIES

NUMBER: 11-W-00114/2

TITLE: Medicaid Redesign Team

AWARDEE: New York State Department of Health

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration.

The following waivers shall enable New York to implement the approved Special Terms and Conditions (STC) for the New York Medicaid Redesign Team (MRT) section 1115 demonstration (formerly the New York Partnership Plan) beginning April 1, 2022, and ending March 31, 2027.

1. Statewideness **Section 1902(a)(1)**

To permit New York to geographically phase in the Managed Long-Term Care (MLTC) program and the Health and Recovery Plans (HARP) and to phase in Behavioral Health (BH) Home and Community Based Services (HCBS) into HIV Special Needs Plans (HIV SNP).

2. Comparability **Section 1902(a)(10), Section 1902(a)(17)**

a. To enable New York to apply a more liberal income standard for individuals who are deinstitutionalized and receive HCBS through the managed long-term care program than for other individuals receiving community-based long-term care.

b. To the extent necessary to permit New York to waive cost sharing for non-drug benefit cost sharing imposed under the Medicaid state plan for beneficiaries enrolled in the Mainstream Medicaid Managed Care Plan (MMMC) – including HARP and HIV SNPs – and who are not otherwise exempt from cost sharing in 447.56(a)(1).

c. Family of One Non-1915 Children, or "Fo1 Children" – To allow the state to target eligibility to, and impose a participation capacity limit on, medically needy children under age 21 who are otherwise described in 42 Code of Federal Regulations (CFR) § 435.308 of the regulations who: 1) receive Health Home Comprehensive Care Management under the state plan in replacement of the case management services such individuals formerly received through participation in New York's NY #.4125 1915(c) waiver *and* who no longer participate in such waiver due to the elimination of the case management services, but who continue to meet the targeting criteria, risk factors and clinical eligibility standard for such waiver; and 2) receive HCBS 1915(c) services who meet the risk factors, targeting criteria, and clinical eligibility standard for the above-

identified 1915(c) waiver. Individuals who meet either targeting classification will have excluded from their financial eligibility determination the income and resources of third parties whose income and resources could otherwise be deemed available under 42 CFR §435.602(a)(2)(i). Such individuals will also have their income and resources compared to the medically needy income level (MNIL) and resource standard for a single individual, as described in New York's state Medicaid plan.

3. Amount, Duration & Scope **Section 1902(a)(10)(B)**

To enable New York to provide BH HCBS services and the Adult Rehabilitation Services named Community Oriented Recovery and Empowerment (CORE) Services, whether furnished as a state plan benefit or as a demonstration benefit to targeted populations that may not be consistent with the targeting authorized under the approved state plan, in amount, duration and scope that exceeds those available to eligible individuals not in those targeted populations.

4. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable New York to require beneficiaries to enroll in managed care plans, including the MMMC, and MLTC (excluding individuals designated as "Long-Term Nursing Home Stays") and HARPs programs in order to obtain benefits offered by those plans. Beneficiaries shall retain freedom of choice of family planning providers.

5. Reasonable Promptness **Section 1902(a)(8)**

To enable the state to limit the number of medically needy Fo1 Children not otherwise enrolled in the Children's 1915(c) waiver.

Title XIX Requirements Not Applicable to Self-Direction Pilot Program (see Expenditure Authority 8, "Self-Direction Pilot")

6. Direct Payment to Providers **Section 1902(a)(32)**

To the extent necessary to permit the state to make payments to beneficiaries enrolled in the Self Direction Pilot Program to the extent that such funds are used to obtain self-directed HCBS long term care (LTC) services and supports.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITIES

NUMBER: 11-W-00114/2

TITLE: Medicaid Redesign Team

AWARDEE: New York State Department of Health

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by New York for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, until the ending date specified for each authority as listed below, be regarded as expenditures under the state's title XIX plan. These expenditure authorities shall be effective from April 1, 2022, through March 31, 2027, except as otherwise noted.

The following expenditure authorities shall enable New York to implement the approved Special Terms and Conditions (STC) for the New York Medicaid Redesign Team Medicaid Section 1115 demonstration.

1. **Demonstration-Eligible Populations.** Expenditures for healthcare related costs for the following populations that are not otherwise eligible under the Medicaid state plan.

    a. Demonstration Population 2 (Temporary Assistance for Needy Families (TANF) Adult). TANF Recipients. Expenditures for health care related costs for low- income adults enrolled in TANF. These individuals are exempt from receiving a Modified Adjusted Gross Income (MAGI) determination in accordance with 1902(e)(14)(D)(i)(I) of the Act.

    b. Demonstration Population 9 (HCBS Expansion). Individuals who are not otherwise eligible, are receiving HCBS, and who are determined to be medically needy based on New York's medically needy income level, after application of community spouse and spousal impoverishment eligibility and post-eligibility rules consistent with section 1924 of the Act.

    c. Demonstration Population 10 (Institution to Community). Expenditures for health care related costs for individuals moved from institutional nursing facility settings to community settings for long term services and supports who would not otherwise be eligible based on income, but whose income does not exceed the income standard described in STC 4.4(c), and who receive services through the managed long-term care program under the demonstration.

    d. Included in Demonstration Population 12 [Family of One (Fo1) Children]. Medically needy children Fo1 Demonstration children under age 21 with a waiver of 1902(a)(10)(C)(i)(III) who meet the targeting criteria, risk factors, and clinical eligibility

standard for #NY.4125 waiver including intermediate care facilities (ICF), nursing facilities (NF), or Hospital Level of Care (LOC) who are not otherwise enrolled in the Children's 1915(c).

2. **Twelve-Month Continuous Eligibility Period**. Expenditures for health care related costs for individuals who have been determined eligible under groups specified in Table 6 of STC 4.4(e) for continued benefits during any periods within a twelve-month eligibility period when these individuals would be found ineligible if subject to redetermination. This authority includes providing continuous coverage for the Adult Group determined financially eligible using MAGI based eligibility methods. For expenditures related to the Adult Group, specifically, the state shall make a downward adjustment of 2.6 percent in claimed expenditures for federal matching at the enhanced federal matching rate and will instead claim those expenditures at the regular matching rate.

3. **Facilitated Enrollment Services.** Expenditures for enrollment assistance services provided by managed care organizations (MCO), the costs for which are included in the claimed MCO capitation rates.

4. **Demonstration Services for Behavioral Health Provided under Mainstream Medicaid Managed Care**. Expenditures for provision of residential addiction services, crisis intervention and licensed behavioral health practitioner services to MMMC enrollees only and are not provided under the state plan [Demonstration Services 9].

5. **Targeted Behavioral Health HCBS and CORE Services.** Expenditures for the provision of BH HCBS and CORE Services under HARP and HIV SNP that are not otherwise available under the approved state plan [Demonstration Services 8].

6. **Self-Direction Pilot.** Expenditures to allow the state to make self-direction services available to HARP and HIV/SNP enrollees receiving BH HCBS or children meeting targeting criteria for the Children's 1915(c) Waiver and in MMMC receiving HCBS under the Children's Waiver. The program will be in effect from January 1, 2017, through March 31, 2027 [Demonstration Services 8].

7. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

8. **Health-Related Social Needs (HRSN) Services**. Expenditures for health-related social needs services not otherwise covered that are furnished to individuals who meet the qualifying criteria as described in Section 6. This expenditure authority is contingent on compliance with Section 7, as well as all other applicable STCs.

9. **Expenditures for HRSN Services Infrastructure.** Expenditures for payments for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized in Section 6 of the STCs. This expenditure authority is contingent on compliance with Section 7 of the STCs, as well as all other applicable STCs.

10. **Medicaid Hospital Global Budget Initiative.** Expenditures for incentive payments to eligible private not-for-profit hospitals with a 0 percent or less operating margin for meeting data collection requirements, reporting expectations, meeting milestones for transitioning to alternative payment models, and demonstrating improvement in health care quality and equity, as specified in the STCs.

11. **Designated State Health Programs (DSHP).** Expenditures for designated programs, described in these STCs (Section 11), which are otherwise state-funded, and not otherwise eligible for Medicaid payment. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs. These expenditures are specifically contingent on compliance with Section 7, as well as all other applicable STCs.

12. **Health Equity Regional Organization (HERO).** Expenditures for an independent contracted statewide entity designed to develop regionally focused approaches to reduce health disparities, advance health equity, and support the delivery of health-related social needs as described in Section 13.

13. **Workforce Initiatives**. Expenditures for provider student loan repayment and Career Pathway Training programs that meet the criteria as specified in Section 12 of the STCs.

    a. Time limited expenditure authority is granted until four years following the demonstration, in order for the state to pay close-out administrative and monitoring service commitments.

Title XIX Requirements Not Applicable to the HRSN Expenditure Authorities

Comparability; Amount, Duration, and Scope — **Section 1902(a)(10)(B), Section 1902(a)(17)**

To the extent necessary to enable the state to provide a varying amount, duration, and scope of HRSN services to a subset of beneficiaries, depending on beneficiary needs.

Comparability; Provision of Medical Assistance and Reasonable Promptness — **Sections 1902(a)(10)(B), 1902(a)(17), 1902(a)(8)**

To the extent necessary to allow the state to offer HRSN services to an individual who meets the qualifying criteria for HRSN services, including delivery system enrollment, as described in Section 6 of the STCs.

To the extent necessary to allow the state to delay the application review process for HRSN services in the event the state does not have sufficient funding to support providing these services to eligible beneficiaries.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00114/2**

TITLE: **Medicaid Redesign Team**

AWARDEE: **New York State Department of Health**

1. PREFACE

The following are the STCs for the New York Medicaid Redesign Team section 1115(a) Medicaid demonstration (hereinafter "demonstration" or "MRT") to enable the New York State Department of Health (hereinafter "state" or "DOH") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted the state waivers of requirements under section 1902(a) of the Social Security Act (hereinafter "the Act") and expenditure authorities authorizing federal matching of demonstration costs that are not otherwise matchable and which are separately enumerated.

These STCs set forth in detail the nature, character, and extent of federal involvement in the Demonstration and New York's obligations to CMS related to this demonstration. The MRT demonstration will be statewide and is approved from April 1, 2022, through March 31, 2027.

The STCs have been arranged into the following sections:

1. Preface
2. Program Description and Objectives
3. General Program Requirements
4. Populations Affected by and Eligible Under the Demonstration
5. Demonstration Benefits and Enrollment
6. Health-Related Social Needs (HRSN) Services
7. Provider Payment Rate Increase Requirement
8. SUD Program and Benefits
9. Medicaid Hospital Global Budget Initiative
10. Delivery Systems
11. Designated State Health Programs (DSHP)
12. Workforce Initiatives
13. Health Equity Regional Organization (HERO)
14. Monitoring and Reporting Requirements
15. General Financial Requirements

16. Monitoring Budget Neutrality
17. Evaluation of the Demonstration
18. Schedule of Deliverables for the Demonstration

Additional attachments have been included to provide supplementary information and for specific STCs.

A. Home and Community-Based Services (HCBS) Expansion Program Benefits
B. Behavioral Health (BH) HCBS and Community Oriented Recovery and Empowerment (CORE) Services in Health and Recovery Plans (HARP)
C. Mandatory Managed Long-Term Care/Care Coordination Model (CCM)
D. List of Eligible Goods and Services Under BH HCBS Individual Directed Goods and Services
E. Developing the Evaluation Design
F. Preparing the Interim and Summative Evaluation Reports
G. Evaluation Design [Reserved]
H. SUD Implementation Plan
I. SUD Monitoring Protocol [Reserved]
J. HRSN Implementation Plan [Reserved]
K. Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services Protocol [Reserved]
L. Medicaid Hospital Global Budget Initiative Implementation Protocol [Reserved]
M. Provider Rate Increase Attestation Table [Reserved]
N. Approved List of DSHPs
O. DSHP Claiming Protocol [Reserved]
P. Monitoring Protocol for Other Policies [Reserved]
Q. DSHP Sustainability Plan [Reserved]

2. PROGRAM DESCRIPTION AND OBJECTIVES

The state's goal in implementing the Medicaid Redesign Team Section 1115(a) demonstration is to improve access to health services and outcomes for low-income New Yorkers by:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered;
- Expanding coverage with resources generated through managed care efficiencies to additional low-income New Yorkers;
- Advancing health equity, reducing health disparities, and supporting the delivery of HRSN services.

The demonstration is designed to permit New York to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who need long term care and supports. It was

originally approved in 1997 to enroll most Medicaid recipients into MCOs (Medicaid managed care program). As part of the demonstration's renewal in 2006, authority to require some disabled and aged populations to enroll in mandatory managed care was transferred to a new demonstration, the Federal-State Health Reform Partnership (F-SHRP). Effective April 1, 2014, this authority was restored to this demonstration as F-SHRP was phased out.

In 2001, the Family Health Plus (FHPlus) program was implemented as an amendment to the demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without dependent children, who have income greater than Medicaid state plan eligibility standards. FHPlus was further amended in 2007 to implement an employer sponsored health insurance (ESHI) component. Individuals eligible for FHPlus who have access to cost-effective ESHI are required to enroll in that coverage, with FHPlus providing any wrap-around services necessary to ensure that enrollees get all FHPlus benefits. FHPlus expired on December 31, 2013, and became a state-only program, but federal matching funding for state expenditures for FHPlus will continue to be available as a designated state health program through December 31, 2014.

In 2002, the demonstration was expanded to incorporate a family planning benefit under which family planning and family planning related services were provided to women losing Medicaid eligibility and to certain other adults of childbearing age (family planning expansion program). The family planning expansion program expired on December 31, 2013, and became a state plan benefit.

In 2010, the Home and Community Based Services Expansion program (HCBS Expansion program) was added to the demonstration. It covers cost-effective home and community-based services to certain adults with significant medical needs as an alternative to institutional care in a nursing facility. The benefits and program structure mirrors those of existing section 1915(c) waiver programs and aims to cover quality services for individuals in the community, ensure the well-being and safety of the participants and increase opportunities for self-advocacy and self-reliance.

As part of the 2011 extension, the state was authorized to develop and implement two new initiatives designed to improve the quality of care rendered to Partnership Plan recipients. The first, the Hospital-Medical Home (H-MH) project, provided funding and performance incentives to hospital teaching programs in order to improve the coordination, continuity and quality of care for individuals receiving primary care in outpatient hospital settings and facilitate certification of such programs by the National Committee for Quality Assurance as patient-centered medical homes. This demonstration initiative ended on December 31, 2014.

Under the second 2011 initiative, the state would have provided funding, on a competitive basis, to hospitals and/or collaborations or hospitals and other providers for the purpose of developing and implementing strategies to reduce the rate of Potentially Preventable Readmissions for the

Medicaid population. The demonstration initiative was never implemented.

In 2011 CMS began providing matching funding for the state's program to address clinic uncompensated care through its Indigent Care Pool (ICP). This pool expired on December 31, 2014.

In 2012, New York added to the demonstration an initiative to improve service delivery and coordination of long-term care services and supports for individuals through a managed care model. Under the MLTC program, eligible individuals in need of more than 120 days of community-based long-term care are enrolled with managed care providers to receive long term services and supports as well as other ancillary services. Other covered services are available on a fee-for-service basis to the extent that New York has not exercised its option to include the individual in the MMMC program. Enrollment in MLTC was phased in geographically and by group.

The state's goals specific to MLTC are listed below:

- Expanding access to managed long-term care for Medicaid enrollees who are in need of long-term services and supports (LTSS)
- Improving patient safety and quality of care for enrollees in MLTC plans
- Reducing preventable inpatient and nursing home admissions
- Improving satisfaction, safety and quality of life

In April 2013, New York had three amendments approved. The first amendment was a continuation of the state's goal for transitioning more Medicaid beneficiaries into managed care. Under this amendment, the Long-Term Home Health Care Program (LTHHCP) participants began transitioning, on a geographic basis, from New York's 1915(c) waiver into the 1115 demonstration and into managed care. Second, this amendment eliminated the exclusion from MMMC of both foster care children placed by local social service agencies and individuals participating in the Medicaid buy-in program for the working disabled.

Additionally, the April 2013 amendment approved expenditure authority for New York to claim federal financial participation (FFP) for expenditures made for certain DSHP beginning April 1, 2013, through March 31, 2014. These DSHPs were aimed to improve health outcomes for Medicaid and other low-income individuals, and the federal funding was linked to requirements for the state to submit deliverables to demonstrate successful efforts to transform its health system for individuals with developmental disabilities.

A December 2013 amendment was approved to ensure that the demonstration made changes that were necessary in order to coordinate its programs with the Medicaid expansion and other changes made under the Affordable Care Act (ACA) implementation beginning January 1, 2014.

Effective April 1, 2014, CMS approved an amendment to extend several authorities that expired in calendar year 2014. As part of the amendment CMS extended authorities related to the transitioning of parents into state plan coverage and other authorities that provide administrative ease to the state's programs and continuing to provide services to vulnerable populations, i.e. HCBS Expansion program and individuals moved from institutional settings into community-based settings.

Also, effective April 1, 2014, populations receiving managed care or managed long-term care in the 14 counties that encompassed the Federal-State Health Reform Partnership (F-SHRP) demonstration were moved into this demonstration.

An amendment approved on April 14, 2014, allowed New York to take the first steps toward a major delivery system reform through a Delivery System Reform Incentive Payment (DSRIP) program. This amendment to the Partnership Plan demonstration provided for an Interim Access Assurance Fund (IAAF) to ensure that sufficient numbers and types of providers were available in the community to participate in the transformation activities contemplated by the DSRIP Program. The DSRIP program incentivized providers through additional payments beginning in 2015. The amendment also included expenditure authority for DSHPs to allow the state to concentrate resources on the investments necessary to implement its DSRIP program. Savings from the DSRIP program were anticipated to exceed the cost of the DSHP program.

On December 31, 2014, CMS amended the demonstration to enable New York to extend long term nursing facility services to enrollees of New York's MMMC and MLTC populations. Enrollment in MMMC and MLTC was extended to individuals entering residential health care facilities (RHCF) for stays that are classified as permanent. As part of the agreement, the state also instituted an independent LTSS assessment process via an enrollment broker and implemented its Independent Consumer Support Program in areas of the state where services and enrollment were being instituted.

In August 2015, CMS approved New York's request to implement HARP to integrate physical, behavioral health and BH HCBS for Medicaid enrollees with Serious Mental Illness (SMI) and/or SUD to receive services in their own homes and communities. Under the demonstration, HARPs are a separate coverage product that is targeted to Medicaid enrollees that meet need-based criteria for SMI and/or SUD established by the state. HIV SNP under MMMC will also offer BH HCBS services to eligible individuals meeting targeting, risk, and functional needs criteria. All MMMC plans will offer BH benefits in integrated plans including four new demonstration services.

The demonstration was also amended to effectuate eligibility flexibilities for the Adult Group, including allowing adults enrolled in TANF to be enrolled as a demonstration population, without a MAGI determination, extension of continuous eligibility for members of the Adult Group who turn 65 during their continuous eligibility period and temporary coverage for members of the Adult Group who are determined eligible to receive coverage through the

Marketplace.

On November 30, 2016, CMS approved an extension of the demonstration, but in response to comments by the state, that extension was rescinded and superseded by a modified approval effective December 7, 2016. In December 2016, the Partnership Plan was renamed New York MRT. The extension included time-limited authorization to extend the DSRIP program first authorized in 2014, through March 31, 2020. The extension also included a new time-limited DSHP authority to the extent that the state increases its Medicaid expenditures through its DSRIP program and achieves metrics that will result in anticipated cost savings that offset the DSHP expenditures. DSHP funding will be phased down over the demonstration period. The DSRIP and DSHP authorities are intended to be a one-time investment in system transformation that can be sustained through ongoing payment mechanisms and/or state and local initiatives.

The Behavioral Health Self-Direction Pilot was included as part of the renewal. This pilot made self-direction services available to HARP and HIV SNP enrollees receiving BH HCBS. The program is authorized to be in effect from January 1, 2017, through March 31, 2027

On April 19, 2019, CMS approved an amendment to allow a waiver of comparability which permits managed care enrollees to only be assessed a drug copay. The state will not assess the non-drug benefit cost sharing described in the Medicaid state plan.

On August 2, 2019, CMS approved an amendment containing the following changes:

- Allow children with HCBS under the state's 1915(c) Children's Waiver and children placed in foster care through a Voluntary Foster Care Agency (VFCA) to enroll in Mainstream Managed Care or an HIV SNP.
- Continues Medicaid eligibility for Non-1915 children who would have been eligible under the Children's Waiver had case management not been moved under the State Plan as a Health Home service or who were in a non-SSI category and receive HCBS or Health Home (HH) comprehensive case management.
- Include Children's Waiver HCBS and State Plan behavioral health services in the Medicaid managed care benefit package.
- Include children receiving HCBS under the Children's waiver in the Self Direction Pilot for Individual Directed Goods and Services.

On December 19, 2019, CMS approved an amendment with the following changes for Partially Capitated MLTC plans:

- Implement a lock-in policy for partially capitated MLTC plans, pursuant to which enrollees of partially capitated MLTC plans are able to transfer to another partially capitated plan without cause during the first 90 days of a 12-month period and with good cause during the remainder of the period. A member of a partially capitated MLTC plan may transfer to another type of MLTC plan at any time.

- Limit the nursing home benefit in the partially capitated MLTC plan to three months for those enrollees who have been designated as Long-Term Nursing Home Stays (LTNHS) in a skilled nursing or residential health care facility, at which time the individual will be involuntarily disenrolled from the partially capitated MLTC plan and payment for nursing home services will be covered by Medicaid fee for service for individuals that qualify for institutional Medicaid coverage. Consistent with this partially capitated MLTC benefit change, individuals age 21 years of age or older who are dually eligible for Medicare and Medicaid and LTNHS in a nursing home will be excluded from enrollment in a partially capitated MLTC plan.

On October 5, 2021, CMS approved an amendment that added a set of rehabilitative services (as such term is defined in Section 1905(a)(13) of the Social Security Act) called CORE, substitutes for and improves upon four BH HCBS within the HARP and HIV SNP. CORE Services can be found in Attachment B and are available to HARP members and HIV SNP members meeting HARP eligibility criteria for whom such services are recommended by a physician or Licensed Practitioner of the Healing Arts as defined by New York State. Through the transition to CORE Services, the state will improve access to rehabilitation and recovery services for HARP beneficiaries. New York State will ensure continuity of care for individuals for BH HCBS including the four services transitioning to CORE. Individuals receiving or eligible for remaining BH HCBS and the BH HCBS, which directly transition to CORE Services will not receive a reduction in services and/or eligibility based on this demonstration amendment. The list of BH HCBS can also be found in Attachment B.

On March 23, 2022, CMS approved a 5-year extension of the New York Medicaid Redesign Team demonstration. As part of the extension, CMS approved the state's second component of its MLTC amendment request to allow dual eligibles to stay in Mainstream Managed Care Plans that offer D-SNPs once they become eligible for Medicare.

On January 9, 2024 CMS approved an amendment that provides authority for HRSN services and HRSN infrastructure, a Medicaid Hospital Global Budget Initiative, workforce initiatives, a HERO, and DSHP. The amendment also provided the state with SUD demonstration authority.

The overarching goal of this amendment is to advance health equity, reduce health disparities, and support the delivery of social care through Social Care Networks (SCNs) and improve overall quality and health. Through the combination of a Medicaid Hospital Global Budget Initiative, HRSN activities, workforce initiatives, and HERO, the state is working to improve health equity. As a result, CMS considers this amendment a Health Equity Initiative. Additionally, by the end of the demonstration, the state's goal is to have made significant movement towards value-based payment (VBP) strategies, multi-payor alignment, and population health accountability. Each program has individual goals that align with the overall goal:

1. Investments in Health Related Social Needs (HRSN) via greater integration between primary care providers (PCPs) and community-based organizations (CBOs) with a goal of improved quality and health outcomes;
2. Goal of improving quality and outcomes of enrollees in geographies that have a longstanding history of health disparities and disengagement from the health system;
3. Focus on integrated primary care, BH, and HRSN with a goal to improve population health and health equity outcomes for high-risk enrollees including kids/youth, pregnant and postpartum individuals, the chronically homeless, and individuals with SMI and SUD;
4. Workforce investments with a goal of equitable and sustainable access to care in Medicaid
5. Developing regionally-focused approaches, including new value-based payment programs, with a goal of statewide accountability for improving health, outcomes, and equity.

Under the SUD demonstration authority, the state will maintain and enhance access to mental health services, opioid use disorder (OUD) and other SUD services and continue delivery system improvements for these services to provide more coordinated and comprehensive treatment of Medicaid beneficiaries with SUD. The demonstration amendment will provide the state with authority to provide high-quality, clinically appropriate treatment to beneficiaries with SUD while they are short-term residents in residential and inpatient treatment settings that qualify as an IMD. The amendment will also support state efforts to enhance provider capacity, improve the availability of Medication Assisted Treatment (MAT) and improve access to a continuum of SUD evidence-based services at varied levels of intensity, including withdrawal management services.

In alignment with the respective SUD demonstration State Medicaid Director Letter (SMDL)[1], under the SUD program, during the demonstration period, the state seeks to achieve the following goals:

SUD Goals:

1. Increase rates of identification, initiation, and engagement in treatment for SUD.
2. Increase adherence to and retention in treatment.
3. Reduce overdose deaths, particularly those due to opioids.
4. Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.
6. Improve access to care for physical health conditions among beneficiaries with SUD.

[1] See https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes**. The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal FFP for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. **Amendment Process**. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS at least 12 months in advance from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. **Transition and Phase-out Plan Requirements:** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. **Transition and Phase-out Plan Approval.** The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. **Transition and Phase-out Procedures:** The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 35.916(f)(1), or for children in CHIP consider eligibility for other insurance affordability programs under 42 CFR 457.350. For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements for Medicaid found in 42 CFR, part 431 subpart E, including Sections 431.206 through 431.214 or for CHIP found at 42 CFR 457.340(e), including information about a right to review consistent with 42 CFR 457.1180. In addition, the state must assure all applicable Medicaid appeal and hearing rights are afforded to Medicaid beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including Sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain Medicaid benefits as required in 42 CFR § 431.230.

e. **Exemption from Public Notice Procedures 42 CFR Section 431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. **Enrollment Limitation during Demonstration Phase-Out.** If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. **FFP.** If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.11. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

a. The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

3.13. **FFP.** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. POPULATIONS AFFECTED BY AND ELIGIBILITY UNDER THE DEMONSTRATION

4.1. **Eligible under the Medicaid State Plan (State Plan Eligibles).** Mandatory and optional Medicaid state plan populations derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as further described in these STCs. Should the state amend the state plan to make any changes to eligibility for Medicaid mandatory populations, upon submission of the state plan amendment, the state must notify CMS in writing of the pending state plan amendment. The Medicaid Eligibility Groups (MEGs) listed in the Reporting and the Budget Neutrality sections of the STCs will be updated upon approval of changes to State plan eligibility and will be considered a technical change to the STCs.

4.2. **Individuals Not Otherwise Eligible under the Medicaid State Plan**. Beneficiary eligibility groups who are made eligible for the demonstration by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid laws or regulations, except for those identified as non-applicable in the expenditure authorities for this document. Eligibility criteria are described elsewhere in this section. Individuals made eligible under this demonstration by virtue of the expenditure authorities expressly granted include:

a. Individuals in the HCBS Expansion program;

b. Individuals moved from Institutional Settings to Community Settings and receiving MLTC but who would have excess income or resources under the state plan;

c. Adults who are receiving TANF benefits and have not been determined eligible using MAGI-based methods;

d. Individuals previously eligible in the adult group who are no longer eligible in that group but are still within a 12-month continuous eligibility period;

e. Children under age 21 who are medically needy (both Supplemental Security Income (SSI)-related and non-SSI related) and have parental income and resources (if applicable) waived and otherwise meet eligibility criteria for 1915(c) waiver #.4125 as Fo1 Demonstration children;

f. People who are not eligible under the Children's waiver. Note: Unlike the Fo1 Children's (Demonstration Population 12) expenditures authorized under section 1115(a)(2) in these STCs, additional Family of One Children (SSI-related) that receive their HCBS under the state's Children's 1915(c) Waiver do not require this demonstration's expenditure authority.

4.3. **Program Components.** The Medicaid Redesign demonstration includes two distinct components—MMMC and MLTC —each of which affects different populations, some of which are eligible under the state plan and some of which are eligible only as an expansion population under the demonstration. In addition, subsets of MMMC and MLTC are eligible for additional benefits. Table 1 summarizes the Medicaid state plan populations that are affected by the demonstration. In addition, the following expansion populations must participate in MLTC: Demonstration Population 9 (HCBS Expansion) and Demonstration Population 10 (Institution to Community). More detailed descriptions follow.

Table 1: State Plan Populations Affected by the Demonstration

State Plan Mandatory and Optional Groups	**MMMC: Medicaid-eligible; not otherwise excluded from MMMC enrollment (includes HARP and SNP for eligible individuals)**	**MLTC: Need more than 120 days of community- based long-term care services**
Pregnant Women		
Pregnant women (42 CFR § 435.116) Income up to 218% of FPL Pregnant minors under age 21 (42 CFR § 435.222) No income test	Demonstration Population 2 [TANF Adult]	Without Medicare: Demonstration Population 5 [Non Duals 18-64] With Medicare: Demonstration Population 7 [MLTC Adult Age 18-64 Duals]
Children		
Infants (218% FPL) and children under age 19 (149% FPL) (42 CFR § 435.117 and § 435.118)	Demonstration Population 1 [TANF Child]	N/A

State Plan Mandatory and Optional Groups	MMMC: Medicaid-eligible; not otherwise excluded from MMMC enrollment (includes HARP and SNP for eligible individuals)	MLTC: Need more than 120 days of community- based long-term care services
Children age 19 and 20 (42 CFR § 435.222) Income up to 133% of FPL if living alone and 150% if living with parents	Demonstration Population 1 TANF CHILD	Without Medicare: Demonstration Population 5 [Non Duals 18-64] With Medicare: Demonstration Population 7 [MLTC Adult Age 18-64 Duals]
Medically needy children age 19 and 20 (42 CFR § 435.308) Income at or below the monthly income standard or with spenddown	N/A	Without Medicare: Demonstration Population 5 [Non Duals 18-64] With Medicare: Demonstration Population 7 [MLTC Adult Age 18-64 Duals]
Adults		

State Plan Mandatory and Optional Groups	MMMC: Medicaid-eligible; not otherwise excluded from MMMC enrollment (includes HARP and SNP for eligible individuals)	MLTC: Need more than 120 days of community- based long-term care services
Adult group (42 CFR § 435.119) Over age 18, under age 65, non-disabled, non- pregnant with income up to 133% of FPL, not eligible for Medicare Part A or B benefits, not eligible under the parents and other caretaker relative group, the foster care child group, or the former foster care child group.	Demonstration Population 11 [New Adult Group]	New Adult Group: Demonstration Population 11
Parents and Caretakers		
Parents and other caretaker relatives (42 CFR § 435.110 and § 435.220) Income up to 133% of FPL Includes low-income adults enrolled in TANF who are exempt from receiving a MAGI determination in accordance with § 1902(e)(14)(D)(i)(I) of the Act. Includes Transitional Medical Assistance under sections 1902(a)(52) and (e)(1); 1925; and 1931(c)(2) of the Social Security Act	Demonstration Population 2 [TANF Adult]	Without Medicare: Demonstration Population 5 [Non Duals 18-64] With Medicare: Demonstration Population 7 [MLTC Adult Age 18-64 Duals]
State Plan Mandatory and Optional Groups	**MMMC: Medicaid-eligible; not otherwise excluded from MMMC enrollment (includes HARP and SNP for eligible individuals)**	**MLTC: Need more than 120 days of community- based long-term care services**

State Plan Mandatory and Optional Groups	MMMC: Medicaid-eligible; not otherwise excluded from MMMC enrollment (includes HARP and SNP for eligible individuals)	MLTC: Need more than 120 days of community- based long-term care services
Medically needy parents and other caretaker relatives (42 CFR 435.310) Income at or below the monthly income standard or with spenddown	N/A	Without Medicare, Demonstration population 5 [Non Duals 18-64] With Medicare, Demonstration population 7 [MLTC Adult Age 18-64 Duals]
Disabled		
Blind and disabled individuals age 64 and under receiving SSI (42 CFR §435.120)	Voluntarily enrolled or required to enroll in managed care in those counties participating in the MRT (formerly Partnership Plan) as of October 1, 2006, Demonstration Population 3 [SSI 0 through-64]	Without Medicare, Demonstration Population 5 [Non Duals 18-64] With Medicare, Demonstration Population 7 [MLTC Adults 18 -64 Duals]

State Plan Mandatory and Optional Groups	MMMC: Medicaid-eligible; not otherwise excluded from MMMC enrollment (includes HARP and SNP for eligible individuals)	MLTC: Need more than 120 days of community- based long-term care services
Medically needy adults/children aged 18 through 64 blind and disabled (42 CFR 435.322 and 324) Income at or below the monthly income standard, or with spend down to monthly income standard	N/A	Without Medicare, Demonstration Population 5 [Non Duals 18-64] With Medicare, Demonstration Population 7 [MLTC Adults 18 -64 Duals]
Aged 18 through 64 Medicaid Buy In for Working People with Disabilities Income up to 250% of FPL	Demonstration Population 2 [TANF Adult]	Without Medicare, Demonstration Population 5 [Non Duals 18-64] With Medicare, Demonstration Population 7 [MLTC Adults 18 -64 Duals]
Aged		

State Plan Mandatory and Optional Groups	MMMC: Medicaid-eligible; not otherwise excluded from MMMC enrollment (includes HARP and SNP for eligible individuals)	MLTC: Need more than 120 days of community- based long-term care services
Aged Individuals Age 65 and Over Receiving SSI (42 CFR 435.120) Optional Adults aged 65 or older (42 CFR 435.210)	Voluntarily enrolled or required to enroll in managed care in those counties participating in the MRT (formerly Partnership Plan) as of October 1, 2006, Demonstration Population 4, [SSI 65 and above]	Without Medicare, Demonstration Population 6 [Non Duals 65+] With Medicare, Demonstration Population 8 [MLTC age 65+ Duals]
Medically needy age 65 and over (42 CFR 435.320) Income at or below the monthly income standard, or with spend down to monthly income standard	N/A	Without Medicare, Demonstration Population 6 [Non Duals 65+] With Medicare, Demonstration Population 8 [MLTC age 65+ Duals]

State Plan Mandatory and Optional Groups	MMMC: Medicaid-eligible; not otherwise excluded from MMMC enrollment (includes HARP and SNP for eligible individuals)	MLTC: Need more than 120 days of community- based long-term care services
State Plan Mandatory and Optional Groups	**MMMC: Medicaid-eligible; not otherwise excluded from MMMC enrollment (includes HARP and SNP for eligible individuals)**	**MLTC: Need more than 120 days of community- based long-term care services**
Foster Care		
Children with adoption assistance, foster care or guardianship under title IV-E (42 CFR 435.145) No income test	Demonstration Population 1 [TANF Child]	N/A
Children in state foster care Children receiving non-IV-E guardianship assistance (42 CFR 435.222) No income test	Demonstration Population 1 [TANF Child]	N/A
Former foster care children up to age 26 (42 CFR 435.150) No income test	Demonstration Population 1 [TANF Child]	N/A

State Plan Mandatory and Optional Groups	MMMC: Medicaid-eligible; not otherwise excluded from MMMC enrollment (includes HARP and SNP for eligible individuals)	MLTC: Need more than 120 days of community- based long-term care services
Independent Foster Care Adolescents 18 through 20 (In foster care on the date of 18th birthday) (42 CFR 435.226) No income test	Demonstration Population 1 [TANF Child]	Without Medicare, Demonstration Population 5 [Non Duals 18-64] With Medicare, Demonstration Population 7 [MLTC Adults 18 -64 Duals]
Children receiving state adoption assistance (42 CFR 435.227) No income test	Demonstration Population 1 [TANF Child]	N/A

a. **MMMC.** This component provides Medicaid state plan and demonstration benefits through a managed care delivery system comprised of MCOs and primary care case management (PCCM) arrangements to most recipients eligible under the state plan. All state plan eligibility determination rules apply to these individuals.

i. **Eligibility.** Table 1 above lists the groups of individuals who receive Medicaid benefits through the mainstream Medicaid managed care component of the demonstration, as well as the relevant expenditure reporting category (demonstration population) for each.

ii. **Exclusions and Exemptions from MMMC**. Notwithstanding the eligibility criteria in STC 4.3, certain individuals cannot receive benefits through the MMMC program (i.e., excluded), while others may opt out from receiving benefits through the MMMC program (i.e., exempted). Excluded individuals are outside the demonstration and are not included in Demonstration

Populations. Exempt individuals are included in the demonstration and in Demonstration Populations regardless of whether they enroll in managed care. Tables 2 and 3 list those individuals either excluded or exempted from MMMC.

Table 2: Individuals Excluded from MMMC (including HARP and HIV SNP)

Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities and residents of Residential Treatment Facilities for Children and Youth
Individuals under age 21 who are permanent residents of Residential Health Care Facilities or temporary residents of Residential Health Care Facilities at time of enrollment
Medicaid eligible infants living with incarcerated mothers
Youth in Office of Children and Family Services (OCFS) facilities and in the care and custody of the Office of Family & Children Services
Individuals with access to comprehensive private health insurance
Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid eligible for less than 6 months (except for pregnant women)
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97, except for individuals in the New York Office of Mental Health family care program who other than their residence in district 97 would be eligible to enroll in MMMC
Individuals with a "county of fiscal responsibility" code of 98 including Individuals in an Office for People with Developmental Disabilities (OPWDD) facility or treatment center
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal or prostate cancer, and who are not otherwise covered under creditable health coverage (Individuals with a "county of responsibility" code of 99)
Individuals who are eligible for Emergency Medicaid
Aliessa Court Ordered Individuals*
Residents of Assisted Living Programs

* Aliessa Aliens are NOT excluded from Managed Care but are excluded from FFP.

Table 3: Individuals who may be exempted from MMMC (including HARP and HIV SNP)

Individuals with chronic medical conditions who have been under active treatment for at least 6 months with a sub- specialist who is not a network provider for any Medicaid MCO in the service area or whose request has been approved by the New York State Department of Health Medical Director because of unusually severe chronic care needs. Exemption is limited to six months.
Child and Youth residents of Residential Rehabilitation Services for Youth (RRSY). Note: as the RRSY services are phased into managed care through contract amendments, the children in RRSYs will mandatorily phase into the demonstration.
Individuals designated as participating in Office for People with Developmental Disabilities (OPWDD)-sponsored programs
Medicare recipients who enroll and remain enrolled in the MMMC plan's aligned Medicare D-SNP
Native Americans
Individuals in the following Section 1915(c) waiver programs: Traumatic Brain Injury (TBI) and Nursing Home Transition & Diversion (NHTD)
Individuals in the Office for People with Developmental Disabilities Home and Community Based Services (OPWDD HCBS) Section 1915(c) waiver program

b. **MLTC**. This component provides a limited set of Medicaid state plan benefits including long term services and supports through a managed care delivery system to individuals eligible through the state plan who require more than 120 days of community based long term care services as indicated on the uniform assessment tool. Services not provided through the MLTC program are provided on a fee-for-service basis. The state has authority to expand mandatory enrollment into MLTC to all individuals identified in under the MLTC column in Table 1 (except those otherwise excluded or exempted as outlined in STC 4.3(b)(ii) of this section).

i. **Eligibility for MLTC.** Table 1 above lists the groups of individuals who may be enrolled in the Managed Long-Term Care component of the demonstration as well as the relevant expenditure reporting category (demonstration population) for each. To be eligible, all individuals in this program must need more than 120 days of community based long term care services and for Medicaid Advantage Plus (MAP) and Program of All- Inclusive Care for the Elderly (PACE) also have a nursing home level of care.

ii. **Exclusions and Exemptions from MLTC.** Notwithstanding the eligibility criteria in STC 4.3 of this section, certain individuals cannot receive benefits through the MLTC program (i.e., excluded) while others may request an exemption from receiving benefits through the MLTC program (i.e.,

exempted). Excluded individuals are outside the demonstration and are not included in Demonstration Populations. Exempt individuals are included in the demonstration and in Demonstration Populations regardless of whether they enroll in managed care. Tables 4 and 5 list those individuals either excluded or exempted from MLTC.

iii. **Non-duplication of Payment**. MLTC Programs will not duplicate services included in an enrollee's Individualized Education Program under the Individuals with Disabilities Education Act, or services provided under the Rehabilitation Act of 1973.

Table 4: Individuals excluded from MLTC

Residents of psychiatric facilities (stays exceeding 30 days)
Residents of skilled nursing or residential health care facilities who have been designated as Long Term Nursing Home Stays (LTNHS) in such facility are excluded from enrollment in a partially capitated MLTC plan.
Residents of skilled nursing or residential health care facilities who are enrolled in a partially capitated MLTC plan are ineligible to continue their MLTC plan enrollment if they are LTNHS for more than three months.
Individuals expected to be Medicaid eligible for less than six months
Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
Individuals with a "county of fiscal responsibility" code 99 in Medicaid Management Information System (MMIS) (Individuals eligible only for breast and cervical cancer services)
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (Individuals residing in a state Office of Mental Health facility)
Individuals with a "county of fiscal responsibility" code of 98 including Individuals in an Office for People with Developmental Disabilities (OPWDD) facility or treatment center
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention (CDC) breast, cervical, colorectal and/or prostate early detection program and need treatment for breast, cervical, colorectal or prostate cancer and who are not otherwise covered under creditable health coverage
Residents of intermediate care facilities for individuals with intellectual disabilities (ICF/IID)

Individuals who could otherwise reside in an ICF/IID, but choose not to
Residents of alcohol/substance abuse long term residential treatment programs
Individuals eligible for Emergency Medicaid
Individuals in the Office for People with Developmental Disabilities Home and Community Based Services (OPWDD HCBS) section 1915(c) waiver program
Individuals in the following section 1915(c) waiver programs: Traumatic Brain Injury (TBI), Nursing Home Transition & Diversion (NHTD) (see Attachment C)
Residents of Assisted Living Programs
Individuals in receipt of Limited Licensed Home Care Services
Individuals in the Foster Family Care Demonstration
Aliessa Court Ordered Individuals*

* Aliessa Aliens are NOT excluded from Managed Care but are excluded from FFP.

Table 5: Individuals who may be exempted from MLTC

Individuals aged 18 through 20 who are nursing home certifiable and require more than 120 days of community based long term care services
Native Americans
Individuals who are eligible for the Medicaid buy in for the working disabled and are nursing home certifiable

c. **Home and Community Based Services Expansion Program (HCBS Expansion).** This component provides home and community-based services similar to those provided under the state's section 1915(c) HCBS waivers Nursing Home Transition and Diversion Program (NHTD), and Traumatic Brain Injury (TBI) Program to certain medically needy individuals. These services enable these individuals to live at home with appropriate supports rather than in a nursing facility. See Attachment A for HCBS Expansion services. All HCBS Expansion individuals will be transitioned as appropriate to MLTC.

i. **Eligibility for the HCBS Expansion.** This group, identified as Demonstration Population 9/HCBS Expansion, includes married medically needy individuals[2]:

[2] Medically needy refers to those who have the option of spousal impoverishment budgeting, including post

1. who meet a nursing home level of care;
2. whose spouse lives in the community; and
3. who would be income-eligible for Medicaid services in the community but for the application of the spousal impoverishment eligibility and post-eligibility rules of section 1924 of the Act.

d. **HARP**: This component provides integrated Medicaid covered services and services specifically to address the needs of individuals with a SMI and SUD conditions under the demonstration. Members enrolled in the Health and Recovery Plans described below may elect to remain enrolled in mainstream MCOs. Within the HARPs, a benefit package of BH HCBS and Community Oriented Recovery and Empowerment (CORE) Services are provided, in addition to the existing MMMC benefit package (excluding long term nursing facility services). See Attachment B for a listing of BH HCBS and CORE Services.

i. **Eligibility for HARP.** Eligible individuals include Medicaid adult beneficiaries age 21 or over eligible for Medicaid furnished in MMMC under the demonstration with a specified SMI and/or serious SUD diagnosis and who meet categorical criteria or risk factors specified by New York's Office of Mental Health (OMH) or New York's Office of Addiction Services and Supports (OASAS) identified by a:

1. review of behavioral health service utilization, or
2. receipt of a qualifying score on a state-approved assessment tool.

4.4. Population-Specific Program Requirements

a. **MMMC Enrollment of Individuals Living with HIV**. The state is authorized to require individuals living with HIV to receive benefits through MMMC. Individuals living with HIV will have 30 days in which to select a health plan. If no selection is made, the individual will be auto-assigned to an MCO. Individuals living with HIV who are enrolled in an MCO (voluntarily or by default) may request transfer to an HIV SNP at any time if one or more HIV SNPs are in operation in the individual's district. Further, transfers between HIV SNPs will be permitted at any time. Individuals in HIV SNPs will be eligible for BH HCBS if meeting the targeting, risk and functional needs requirements for BH HCBS. Individuals in HIV SNPs will be eligible for CORE if they otherwise would meet HARP eligibility criteria. HIV

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eligibility when it is more beneficial. Medically needy is defined as an individual who is not eligible for, or in receipt of public assistance or SSI (or the state supplement), because his/her income and/or resources are in excess of cash assistance standards, but who has insufficient income and/or resources to meet the cost of his/her necessary medical and remedial care (42 CFR 435.320 (aged), 435.322 (blind) and 435.324 (disabled)).

SNPs will meet all requirements of MMMC plans providing LTSS as well as HARP plans relating to delivery of BH HCBS and CORE.

b. **Restricted Recipient Programs.** The state may require individuals participating in a restricted recipient program administered under 42 CFR 431.54(e) to enroll in MMMC or MLTC. Furthermore, MCOs may establish and administer restricted recipient programs, through which they identify individuals that have utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the state, and restrict them for a reasonable period of time to obtain Medicaid services from designated providers only. The state must adhere to the following terms and conditions in this regard.

    i. Restricted recipient programs operated by MCOs must adhere to the requirements in 42 CFR 431.54(e) (1) through (3), including the right to a hearing conducted by the state.

    ii. The state must require MCOs to report to the state whenever they want to place a new person in a restricted recipient program. The state must maintain summary statistics on the numbers of individuals placed in restricted recipient programs, and the reasons for those placements, and must provide the information to CMS upon request.

c. **Individuals Moved from Institutional Settings to Community Settings for Long Term Services and Supports.** Individuals discharged from a nursing facility who enroll into or remain enrolled in the MLTC program in order to receive community based long term services and supports or who move from an adult home as defined in subdivision 25 of section 2 of the social services law, to the community and, if applicable, enroll into the MLTC program, are eligible based on a special income standard. The special income standard is also available to MLTC members who were enrolled in the program as a result of the mandatory Nursing Facility transition, and subsequently able to be discharged to the community from the nursing facility, with the services of MLTC program in place. For married individuals who meet the criteria to be considered an "institutionalized spouse," spousal impoverishment rules shall apply. Eligibility is not based on the special income standard for individuals subject to spousal impoverishment rules. The special income standard will be determined by utilizing the average Department of Housing and Urban Development (HUD) Fair Market Rent (FMR) dollar amounts for each of the seven regions in the state, and subtracting from that average, 30 percent of the Medicaid income level (as calculated for a household of one) that is considered available for housing. The seven regions of the state include: Central, Northeastern, Western, Northern Metropolitan, New York City, Long Island and Rochester.

The state shall work with Nursing Home Administrators, nursing home discharge planning staff, family members and the MLTC health plans to identify individuals who may qualify for the housing disregard as they are able to be discharged from a nursing facility back into the community and remain enrolled in or newly enrolled into the MLTC program.

Enrollees receiving community based long term services and supports must be provided with nursing facility coverage through managed care, if nursing facility care is needed for 120 days or less and there is an expectation that the enrollee will return to community-based settings. During the short-term nursing facility stay, the state must retain the enrollees' community maintenance needs allowance. In addition, the state will ensure that the MLTC MCOs work with individuals, their families, nursing home administrators, and discharge planners to help plan for the individual's move back into the community, as well as to help plan for the individual's medical care once he/she has successfully moved into his/her home. For dually eligible enrollees, the MCO is responsible for implementing and monitoring the plan of care between Medicare and Medicaid. The MCO must assure the services are available to the enrollee.

d. **Continuous Eligibility Period**

i. **Duration**. The state is authorized to provide a 12-month continuous eligibility period to the groups of individuals specified in Table 6, regardless of the delivery system through which they receive Medicaid benefits. Each newly eligible individual's 12-month period shall begin at the initial determination of eligibility; for those individuals who are re-determined eligible consistent with Medicaid state plan rules, the 12-month period begins at that point. At each annual eligibility redetermination thereafter, if an individual is re-determined eligible under the Medicaid state plan the individual is guaranteed a subsequent 12-month continuous eligibility period. 12-month continuous eligibility is also authorized for the Adult Group under section 1902(a)(10)(A)(i)(VIII) of the Act.

ii. **Exceptions**. Notwithstanding subparagraph (a), if any of the following circumstances occur during an individual's 12-month continuous eligibility period, the individual's Medicaid eligibility shall be terminated, suspended or re-determined:

1. The individual cannot be located;
2. The individual is no longer a New York State resident;
3. The individual requests termination of eligibility;
4. The individual dies;

5. The individual fails to provide, or cooperate in obtaining a Social Security Number, if otherwise required;
6. The individual provided an incorrect or fraudulent Social Security Number;
7. The individual was determined eligible for Medicaid in error;
8. The individual is receiving treatment in a setting where Medicaid eligibility is not available (e.g. institution for mental disease);
9. The individual is receiving care, services or other supplies under a section 1915 waiver;
10. The individual was previously otherwise qualified for emergency medical assistance benefits only, based on immigration status, but is no longer qualified because the emergency has been resolved;
11. The individual fails to provide the documentation of citizenship or immigration status required under federal law;
12. The individual is incarcerated;
13. The individual turns 65 years of age and is no longer eligible for the Adult Group;
14. The individual policy holder fails to provide documentation of third-party health insurance.

Table 6: Groups Eligible for a 12 Month Continuous Eligibility Period

State Plan Mandatory and Optional Groups	Statutory or Regulatory Reference
Individuals determined eligible as pregnant women	42 CFR § 435.116
Individuals determined eligible as the Adult Group	42 CFR § 435.119
Individuals determined eligible as parents or other caretaker relatives	42 CFR § 435.110
Low-income families, except for children	§ 1931 of the SSA

5. DEMONSTRATION BENEFITS AND ENROLLMENT

5.1. **Alternative Benefit Plan**. The Affordable Care Act Adult Group will receive benefits provided through the state's approved Alternative Benefit Plan (ABP) SPA.

5.2. **Demonstration Benefits**. The following benefits are provided through the indicated delivery system to individuals eligible for the Medicaid managed care components of the demonstration:

a. **MMMC.** State plan and demonstration benefits are delivered through MCOs with the exception of certain services carved out of the MMMC contract and delivered directly by the state on a fee-for-service basis. All MMMC benefits (regardless of delivery method), as well as the co-payments charged to MMMC recipients. In addition to state plan benefits, there are three demonstration services provided only to all enrollees in MMMC under the demonstration.

i. **Cost Sharing for MMMC.** MMMC beneficiaries including HARPs and HIV-SNPs, who are not otherwise exempt from cost sharing consistent with 447.56(a)(1), will be charged drug copays that are approved in the Medicaid state plan. MMMC beneficiaries will not be subject to any non-drug copays that are described in the Medicaid state plan.

ii. **Children's HCBS.** MMMC plans will provide HCBS for children not otherwise excluded or exempted from MMMC under the concurrent authority of the 1915(c) Children's waiver and this 1115 demonstration. Independent assessments and person-centered services planning for HCBS under the Children's waiver will be conducted by a State Plan Health Home provider or the state's Independent Entity as described and included in the approved Children's waiver. All HCBS benefits are listed in the approved Children's waiver or the approved State Plan for Community First Choice Option (CFCO). All reimbursement for Children's Waiver HCBS will be non-risk for the first 24 months subject to the non-risk UPL at 42 CFR 447.362. The MCO must pay the FFS fee schedule for non-risk services as long as the HCBS are non-risk (i.e., 24 months). There are no co-payments for Children's waiver services.

b. **Managed Long Term Care.** State plan benefits are delivered through MCOs or, in certain districts, prepaid inpatient health plans, with the exception of certain services carved out of the MLTC contract and delivered directly by the state on a fee-for-service basis.

i. For those individuals receiving a nursing home benefit in the partially capitated MLTC plan they will be limited to three months for those enrollees who have been designated as LTNHS in a skilled nursing or residential health care facility as of the effective date of this amendment. After three months the individual will be involuntarily disenrolled from the partially capitated MLTC plan and payment for nursing home services will be covered by Medicaid fee for service for individuals who qualify for institutional Medicaid coverage.

ii. Should an individual prefer discharge—and an assessment of the individual's medical needs indicates they may be safely discharged to the community—they may remain enrolled in their MLTC plan, while residing in the nursing home on a temporary basis for more than three months, until their discharge plans are resolved, and the individual is transitioned out of the nursing home.

c. **Health and Recovery Plans (HARP).** State plan and demonstration benefits that are identical to MMMC with an additional component that provides BH HCBS and CORE for SMI and SUD needs will be provided by the HARPs. Long term care services (in excess of 120 days) or permanent placement in a Nursing facility, however, are not provided by HARPs. There are no co-payments for HARP services. All BH HCBS and CORE benefits are listed in Attachment B. CORE Services for HARP enrollees and BH HCBS for HARP enrollees meeting targeting, risk, and need-based functional criteria are only provided under the demonstration. The state must update the Medicaid state plan for rehabilitation and other mental health and substance use disorder services as identified through a companion letter to TN 10-38 as well as substance use disorder demonstration services not described in the current state plan. HIV SNPs also provide CORE to enrollees meeting HARP eligibility criteria and BH HCBS to enrollees meeting targeting, risk, and need-based criteria. The state will adhere to all state plan requirements pertaining to comparability. Below is a table showing how the state defines its services under CORE, and how this compares to services under BH HCBS.

Table 7 – BH HCBS and CORE

Existing BH HCBS before CORE	Service Crosswalk after CORE Transition
BH HCBS Community Psychiatric Support & Treatment (CPST)	CORE Community Psychiatric Support & Treatment (CPST)
BH HCBS Family Support and Training (FST)	CORE Family Support and Training (FST)
BH HCBS Empowerment Services – Peer Support	CORE Empowerment Services – Peer Support
BH HCBS Psychosocial Rehabilitation (PSR)	CORE Psychosocial Rehabilitation (PSR)
BH HCBS Short-Term Crisis Respite	Crisis Intervention, including Short-Term Crisis Respite – already available to all Medicaid managed care recipients
BH HCBS Intensive Crisis Respite	Crisis Intervention, including Intensive Crisis Respite – already available to all Medicaid managed care recipients
BH HCBS Education Support Services	No change

BH HCBS Pre-Vocational Services	No change
BH HCBS Transitional Employment	No change
BH HCBS Intensive Supported Employment	No change
BH HCBS Ongoing Supported Employment	No change
BH HCBS Habilitation	No change
BH HCBS Non-Medical Transportation	No change

i. **HARPs Services Tiers.** HARP enrollees receive BH HCBS services under the following tier structure in accordance with their person-centered plan of care. HARP enrollees are permitted to appeal any service denial decisions.

1. Tier 1 BH HCBS services include:
    a. Employment supports
    b. Education supports
2. Tier 2 includes all Tier 1 BH HCBS services plus additional services as specified in Attachment J to individuals whose medical need surpasses the need for Tier 1 services.

ii. **HARPs Services Utilization Thresholds.** The following thresholds will limit coverage of HARPs-specific services for individual HARPs enrollees. These limits will not affect state plan or other demonstration benefits. The state will track and report overall utilization, including any utilization threshold exceeded for clinical reasons, to ensure cost containment as well as compile sufficient fee for service data to submit HARPs capitation rates to CMS for approval.

1. Tier 1 — Threshold of $8,000 per person, per 12-month period. Up to $10,000 in services are permitted. For ROS, the thresholds will be adjusted to reflect the HCBS rate differentials.
2. Tier 2 — Threshold of $16,000 per person, per 12-month period. Up to $20,000 in services are permitted. For ROS, the thresholds will be adjusted to reflect the HCBS rate differentials.

iii. **Self-Direction Pilot.** The Self-direction Demonstration will be available to HARP and HIV/SNP enrollees eligible for receiving BH HCBS services or children meeting the target criteria of the Children's waiver and receiving HCBS under the Children's waiver through MMMC. The program will be in effect from January 1, 2017, through March 31, 2027. It will include 8 pilot sites phased in over the demonstration.

1. **Voluntary Enrollment and Disenrollment from Self-Direction Pilot.** Participation in the Self-Direction pilot is voluntary, and participants may opt out at any time.
2. **Enrollee Notification.** The state must notify eligible enrollees about the option to self-direct services. The state must develop a waiting list for enrollees who wish to participate in the pilot should the demand exceed capacity.
3. **Choice of Providers.** Self-direction pilot participants will have a choice of support broker within the service center. Each participant should have the choice of provider and location for self-directed services, except as noted in 5.2(c)(iii)(5) below.
4. **Services Eligible for Self-Direction:** This pilot includes all behavioral health HCBS services offered by HARPs and HIV SNPs and Individual Directed Goods and Services (IDGS) detailed in Attachment D. Children meeting targeting criteria of the 1915(c) Children's waiver and receiving HCBS through MMMC are eligible to self-direct up to $2,000 in IDGS only using a Fiscal Management Services provider within the service center. Each participant will have the choice of provider and location for IDGS. Children's IDGS should be used as the funding source of last resort – only for those costs that cannot be covered by any other source and that are vital to the implementation of the POC. Individual Directed Goods and Services are services, equipment, or supplies not otherwise provided through this waiver, the 1915(c) Children's Waiver, or through the Medicaid State Plan that address an identified need in the service plan. The item or service must be identified in the service plan and either:
    a. decrease the need for other Medicaid services;
    b. promote inclusion in the community; or
    c. increase the participant's safety in the home environment.
    d. To be an eligible service:
        i. the participant must lack funds to purchase the item or service; and
        ii. the service is not available through another source.
5. **Services Ineligible for Self-Direction:** Individual goods and services that are not eligible are listed below.
    a. Experimental or prohibited treatments;
    b. Purchases for or from third parties who are family members, friends, or significant others aside from family or social functions that promote social inclusion and are incorporated in

the service plan;

c. Room and Board in a residential facility, including assisted living facilities;

d. Tobacco products, alcohol products, firearms, contraband or illegal items;

e. Pornographic materials, prostitution services, escort services;

f. Payment of court-ordered costs, attorney fees, fines, restitution, or similar debts;

g. Credit card payments of any kind, or similar debts;

h. Items purchased for the purpose of resale;

i. Gift cards or prepaid debit cards;

j. Services or goods that are recreational in nature;

k. Goods and services not in the service plan or related to a recovery goal, or that is solely for recreation that a household does not include a person with a disability would be expected to pay for as a household expense (e.g. subscription to a cable television service).

6. **Evaluation.** The state shall follow the evaluation requirements specified in Section 17 below.

7. **Reporting.** Information from the pilot must be incorporated into the quarterly and annual reports detailed in STC 14.7.

8. **Protocols.** Payment and operational protocols must be submitted by New York to CMS within 120 days of award.

5.3. **Home and Community Settings Qualities.** Enrollees receiving Medicaid HCBS and LTSS services furnished through the 1115 demonstration, including individuals who receive services under the demonstration's HCBS Expansion program, MMMC and HARP, including HIV SNP, must receive services in residential and non-residential settings located in the community, which meet CMS standards for HCBS settings as articulated in current 1915(c) policy, including regulations at 42 CFR §441.301. The Statewide Transition Plan must include HARPs BH HCBS settings and meet CMS approval for required settings to be funded beyond November 30, 2015. A full list of home and community-based qualities are provided in Attachment A.

5.4. **Individuals Provided with LTSS under the Demonstration.** The state is authorized to require certain individuals using long term services and supports to enroll in either Mainstream Medicaid Managed Care, or Managed Long-Term Care as identified in

Section I. Once these individuals are enrolled in managed care, the state is required to provide the following protections for the population.[3]

5.5. **Person Centered Service Planning.** All individuals utilizing long term services and supports will have a person-centered individual service plan maintained at the MCO. Person-centered planning includes consideration of the current and unique psycho- social and medical needs and history of the enrollee, as well as the person's functional level, and support systems. The person-centered plan is developed by the enrollee with the assistance of the MCO and individuals the enrollee chooses to include.

When a service provider is an approved State Plan Health Home[4] provider and also a HCBS provider, this entity may conduct person-centered service planning, care coordination, and provision of HCBS provision as long as firewalls are constructed between the service planning, care coordination, and service provision. A home and community-based service provider who is not also an approved State Plan Health Home provider may not conduct person-centered service planning with individuals who they also provide HCBS, unless that service provider is the only qualified and willing entity available to conduct the service planning. If a service provider is the only willing and qualified entity to conduct service planning, the state must require such provider to establish firewalls between the service provision and planning functions. The person-centered plan is developed in accordance with 42 CFR 441.301(c)(4)(F)(1) through (8).

a. Health home program will have administrative safeguards in place when providing person-centered planning and care coordination and services that have transitioned from 1915(c) waivers to eligible health home individuals. In addition, the state agrees to meet all health home requirements including reporting annually on quality and utilization measures.

5.6. **Verification of MLTC Plan Enrollment.** The state shall implement a process for MLTC plans, network and non-network providers for the state to confirm enrollment of enrollees who do not have an enrollee identification card or seek services from a provider before developing a person-centered service plan.

5.7. **Health and Welfare of Enrollees.** The state shall ensure a system is in place to identify, address, and seek to prevent instances of abuse, neglect, and exploitation of its enrollees on a continuous basis. This should include provisions such as critical incident monitoring and reporting to the state, investigations of any incident including, but not limited to, wrongful death, restraints, or medication errors that resulted in an injury. In each quarterly report, the state will provide information regarding any such incidents by plan. The state

[3] All beneficiary protections apply to MMMC, MLTC and HARPs, unless otherwise noted in STC 5

[4] Throughout these STCs, the term "Health Home," unless otherwise noted, *only* refers to Health Homes approved under section 1945 of the Act and consistent with approved NY Health Home state plan benefits for Health Homes SPA for IDD, Health Homes SPA for children, and/or Health Home SPA for Chronic Medical and SSI Health Home program.

will also ensure that children and adults receiving MLTC or LTSS are afforded linkages to child and/or adult protective services through all service entities, including the MCOs.

5.8. **Maintaining Accurate Beneficiary Address.** New York will complete return mail tracking for enrollment notification mailings. The state will use information gained from returned mail to make additional outreach attempt through other methods (phone, email, analysis of prior claims, etc.).

5.9. **Network of Qualified Providers.** The provider credentialing criteria described at 42 CFR 438.214 must apply to all providers participating in the state's Medicaid managed care and managed long-term care programs. To the extent possible, the MCO shall incorporate criminal background checks, reviewing abuse registries as well as any other mechanism the state includes within the MCO contract.

5.10. **MMMC or MLTC Enrollment and Transition of Care Period.** For initial transitions into MLTC or MMMC from fee-for-service, each enrollee receiving community-based LTSS must continue to receive services under the enrollee's pre- existing service plan for at least 90 days after enrollment or until a care assessment has been completed. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404 and applicable appeal rights.

5.11. **Option for Consumer Directed Personal Assistance Program (CDPAP)**. Enrollees shall have the option to elect self-direction of Personal Assistance under the MMMC program. The state shall ensure through its contracts with the MCOs that enrollees are afforded the option to select self-direction and enrollees are informed of Consumer Directed Personal Assistance Program (CDPAP) as a voluntary option. Individuals who select self-direction must have the opportunity to have choice and control over how services are provided and who provides the service, except as noted in STC 5.2(c)(iii)(5) of this section.

5.12. **Information and Assistance in Support of Participant Direction**. The state/MCO shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option.

5.13. **Participant Direction by Representative.** The participant who self-directs the personal care service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. Services may be directed by a legal representative of the participant. Consumer-directed services may be directed by a non-legal representative freely chosen by the participant. A person who serves as a representative of a participant for the purpose of directing services cannot serve as a provider of personal attendant services for that participant.

5.14. **Participant Employer Authority**. The participant (or the participant's representative) must have decision making authority over workers who provide personal care services.

a. **Participant.** The participant (or the participant's representative) provides training, supervision and oversight to the worker who provides services. A Fiscal/Employer Agent that follows Internal Revenue Service (IRS) and local tax code laws functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law.

b. **Decision-Making Authorities.** The participants exercise the following decision-making authorities: recruit staff, hire staff, verify staff's ability to perform identified tasks, schedule staff, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.

c. **Disenrollment from Self-Direction.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system through the MMMC, or MLTC program. To the extent possible, the member shall provide his/her intent to withdraw from participant direction. A participant may also be involuntarily disenrolled from the self-directed option if continued participation in the consumer-directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant demonstrates the inability to self- direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct services, or if there is fraudulent use of funds such as substantial evidence that a participant has falsified documents related to participant-directed services. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.

d. Payment for services will be made following the service being rendered and only upon receipt of an acceptable receipt, invoice or signed and approved timesheet, as applicable.

e. **Appeals.** The following actions shall be considered adverse action under both 42 CFR §431 subpart E and 42 CFR §438 subpart F:

i. a reduction, suspension or termination of authorized CDPAP services;

ii. A denial of a request to change Consumer Directed Personal Assistance Program services.

5.15. **Adding Services to the MMMC, and/or MLTC Plan Benefit Package**. At any point in time the state intends to add to either the MMMC, or MLTC plan benefit package currently authorized state plan or demonstration services that have been provided on a fee-

for-service basis, the state must provide Center for Medicaid and CHIP Services (CMCS), Managed Care Group, Division of Managed Care Policy (DMCP) the following information, with at least 30 days' notice prior to the inclusion of the benefit, in writing:

a. A description of the benefit being added to the benefit package;

b. A detailed description of the state's oversight of the MCO's readiness to administer the benefit including:

i. readiness and implementation of activities, including onsite reviews, phone meetings and desk audits that review policies and procedures for new services;

ii. data sharing to allow plans to create services plans as appropriate;

iii. process to communicate the change to enrollees;

iv. MCO network development to include providers of that service; and

v. any other activity performed by the state to ensure plan readiness.

c. Information concerning the changes being made to the MMMC and/or MLTC contract provisions and capitation payment rates in accordance with STC 10.2.

d. DMCP reserves the right to delay implementation of the benefit transition until such time as appropriate documentation is provided showing evidence of MCO readiness. In addition, new services that are not currently authorized under the state plan or demonstration may be added only through approved amendments to the state plan or demonstration.

e. DMCP will notify the state of concerns within 10 days of receiving the state's written notice of the change. If no comments are received, the state may proceed with the scheduled benefit transition.

5.16. **Adding Populations to MMMC and/or MLTC Enrollment**. Any time the state is ready to expand mandatory MMMC and /or MLTC plan enrollment into a new Medicaid population, the state must submit an 1115 amendment in accordance with STC 3.7. The amendment request must include the following:

a. a description of the population and the list of the counties that will have populations moving to mandatory enrollment;

b. a list of MCOs with an approved state certificate of authority to operate in those counties demonstrating that enrollees will be afforded choice of plan that will be providing services;

c. confirmation that the MCOs have met the network requirements in STC 10.22 for each MCO; and

d. an analysis of why the most appropriate authority to implement mandatory MMMC and/or MLTC for the new population, i.e., what the state is demonstrating by implementing the change to the demonstration.

5.17. **Assurances During LTSS Expansion for MMMC, HIV SNP, and HARP Enrollees.** To provide and demonstrate seamless transitions for enrollees, the statemust (where applicable):

a. Send sample notification letters. Existing Medicaid providers must receive sample beneficiary notification letters via widely distributed methods (mail, email, provider website, etc.) so that providers are informed of the information received by enrollees regarding their managed care transition.

b. Provide continued comprehensive outreach, including educational tours for enrollees and providers. The educational tour should educate enrollees and providers regarding plan enrollment options, rights and responsibilities and other important program elements. The state must provide webinars, meeting plans, and send notices through outreach and other social media (e.g., state's website). The enrollment broker, choice counseling entities, ombudsman and any group providing enrollment support must participate.

c. Operate a call center independent of the MLTC, and MMMC, HIV SNP, and HARP plans. This entity must be able to help enrollees in making independent decisions about plan choice and be able to document complaints about the plans. During the first 60 days of implementation the state must review all call center response statistics to ensure all contracted plans are meeting requirements in their contracts. After the first 60 days, if all entities are consistently meeting contractual requirements the state can decrease the frequency of the review of call center statistics, but no more than 120 days should elapse between reviews.

d. Review the outcomes of the auto-assignment algorithm to ensure that MLTC and MMMC plans with more limited networks do not receive the same or larger number of enrollees as plans with larger networks.

e. Require MCO to maintain the current worker/recipient relationship for no less than 90 days.

5.18. **Assessment of LTSS needs for MLTC and MMMC and BH HCBS Assessments for HARPs and HIV SNPs.** LTSS needs assessments must be conflict free plans will not complete any LTSS needs assessments for individuals requesting such services prior to enrollment in a plan. Non-dually eligible individuals requesting LTSS will be assessed for

criteria necessitating enrollment in MLTC or an alternate waiver program. An independent LTSS assessment must be in place in any geographic location where MLTC or, LTSS in MMMC will be mandated. An independent BH HCBS assessment system must be in place in any geographic location where HARP enrollment is an option for eligible individuals. LTSS assessments for skilled nursing facility services in MMMC, and BH HCBS assessments of enrollees aged 21 and over for HARPs and HIV SNPs will be conflict free prior to implementation and geographic phase in.

5.19. **Post Assessment Education**. New Medicaid applicants must be provided the results of their assessment and educated on the steps in the Medicaid eligibility determination, including denial and fair hearing procedures. Individuals who are currently Medicaid eligible must be provided information regarding choice of plan.

5.20. **Operation of the HCBS Expansion Program**. The individuals eligible for this component of the demonstration will receive the same HCBS as those individuals determined eligible for and enrolled in the state's Nursing Home Transition and Diversion Program (NHTDP) and Traumatic Brain Injury Program (TBIP) authorized under section 1915(c) of the Act. The specific benefits provided to participants in this program are listed in Attachment A. The state will operate the HCBS Expansion program in a manner consistent with approved NHTDP and TBIP 1915(c) waiver programs and must comply with all administrative, operational, quality improvement and reporting requirements contained therein. The state shall provide enrollment and financial information about the individuals enrolled in the HCBS Expansion program.

5.21. **Facilitated Enrollment**. Facilitated enrollers, which may include MCOs, health care providers, community-based organizations, and other entities under state contract, will engage in those activities described in 42 CFR 435.904(d)(2), as permitted by 42 CFR 435.904(e)(3)(ii), within the following parameters:

a. Facilitated enrollers will provide program information to applicants and interested individuals as described in 42 CFR 435.905(a).

b. Facilitated enrollers must afford any interested individual the opportunity to apply for Medicaid without delay as required by 42 CFR 435.906.

c. If an interested individual applies for Medicaid by completing the information required under 42 CFR 435.907(a) and (b) and 42 CFR §435.910(a) and signing a Medicaid application, that application must be transmitted to New York State Department of Health for determination of eligibility.

d. The protocols for facilitated enrollment practices between the state and the facilitated enrollers must:

i. Ensure that choice counseling activities are closely monitored to minimize adverse risk selection; and

ii. Specify that determinations of Medicaid eligibility are made solely by the Medicaid agency or its designee.

5.22. **Passive Enrollment**. For any component that requires passive enrollment of potential enrollees, individuals must have the ability to "opt out" where the notice is sent 30 days in advance of the passive enrollment. The individual may opt out at any time after receipt of the notice and within the first 90 days following the passive enrollment. The individual may also change after the 12-month lock-in period at any time. Enrollees who enrolled through the health exchange or the local social services district in an MMMC plan whose MCO also operates a HARP line of business will be passively enrolled with the ability to opt-out within the first 90 days following passive enrollment and return to their original MMMC plan. Following the 90 day opt out period, HARP enrollees may not change plans again until the remainder of the twelve-month lock-in period has lapsed. HARP eligible enrollees in an MMMC plan who's MCO does not operate a HARP line of business will be allowed to voluntarily enroll in a HARP. The enrollee must be given the choice of HARPs available for enrollment and the current plan must assist the enrollee in transferring to the HARP. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria. When a HARP enrollee leaves the HARP and transfers into another plan, care must be coordinated for physical and behavioral health during the transition to best meet the needs of the enrollee. The current and new plans must work together when an enrollee transfers to another plan.

5.23. **HCBS Electronic Visit Verification System**. The state will demonstrate compliance with the Electronic Visit Verification (EVV) System requirements for personal care services (PCS) by January 1, 2020, and home health services by January 1, 2023, in accordance with section 12006 of the 21st Century CURES Act.

5.24. **HCBS Quality Systems and Strategy**. The state is expected to implement systems that measure and improve its performance to meet the waiver assurances set forth in 42 CFR 441.301 and 441.302. The Quality Review provides a comprehensive assessment of the state's capacity to ensure adequate program oversight, detect and remediate compliance issues and evaluate the effectiveness of implemented quality improvement activities.

5.25. **For 1915(c)-Approvable HCBS**, for services that could have been authorized to individuals served under a 1915(c) waiver, the state must have an approved Quality Improvement Strategy and is required to develop and measure performance indicators for the following waiver assurances:

a. **Administrative Authority**: A performance measure should be developed and tracked any authority that the State Medicaid Agency (SMA) delegates to another agency, unless already captured in another performance measure.

b. **Level of Care**: Performance measures are required for the following two sub-assurances: applicants with reasonable likelihood of needing services receive a level of care determination and the processes for determining level of care are followed as documented. While a performance measure for annual levels of care is not required to be reported, the state is expected to be sure that annual levels of care are determined.

c. **Qualified Providers**: The state must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to waiver requirements, and that the state verifies that training is given to providers in accordance with the waiver.

d. **Service Plan**: The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for choice of waiver services and providers, service plans address all assessed needs and personal goals, and services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.

e. **Health and Welfare**: The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants health and welfare. The state must have performance measures that track that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

f. **Financial Accountability**: The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the HCBS program. The state must have performance measures that track that it provides evidence that claims are coded and paid for in accordance with services rendered, and that it provides evidence that rates remain consistent with the approved rate methodology throughout the five-year demonstration cycle.

g. The state will submit a report to CMS which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers. (1915(c) and 1915(i) HCBS). **NOTE**: This information could be captured in the 1115 Summary report detailed in STC 15.9.

5.26. The state must report annually the deficiencies found during the monitoring and evaluation of the HCBS waiver assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. Submission is due no later than 6 months following the end of the demonstration year. **NOTE:** This information could be included in the annual reports submitted for 1115 demonstrations detailed in STC 14.7.

5.27. **For 1915(i)-Approvable HCBS**, for services that could have been authorized to individuals served under a 1915(i) waiver, the state must have an approved Quality Improvement Strategy and is required to develop performance measures to address the following requirements:

a. Service plans that:

i. address assessed needs of 1915(i) participants;

ii. are updated annually; and

iii. document choice of services and providers.

b. Eligibility Requirements: The state will ensure that:

i. an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future;

ii. the processes and instruments described in the approved program for determining 1915(i) eligibility are applied appropriately; and

iii. the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually (end of demonstration year) or if more frequent, as specified in the approved program.

c. Providers meet required qualifications.

d. Settings meet the home and community-based setting requirements as specified in the benefit and in accordance with 42 CFR 441.710(a)(1) and (2).

e. The State Medicaid Agency (SMA) retains authority and responsibility for program operations and oversight.

f. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

g. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.

h. The state must also describe the process for systems improvement as a result of aggregated discovery and remediation activities.

5.28. **Person-centered planning**. The state assures there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR 441.301(c)(1) (1915(c)) or 42 CFR 441.725(c) (1915(i)), and the written person-centered service plan meets federal requirements at 42 CFR 441.301(c)(2) (1915(c)) or 42 CFR 441.725(b) (1915(i)). The person-centered service plan is reviewed and revised upon reassessment of functional need as required by 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

5.29. **Conflict of Interest**: The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCBS services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies except for as stated in STC 5.5.

a. Each beneficiary eligible for long term services and supports will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care and person- centered service planning personnel will receive training on these options. (Managed Long Term Services and Supports (MLTSS) with self-direction)

b. The state, either directly or through its MCO contracts must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant. (MLTSS)

c. The state will assure compliance with the characteristics of HCBS settings as described in 1915(c) regulations in accordance with implementation/effective dates as published in the Federal Register.

d. Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan. (MLTSS)

6. HEALTH-RELATED SOCIAL NEEDS (HRSN) SERVICES

6.1. **HRSN Services.** The state may claim FFP for expenditures for certain qualifying HRSN services identified in Attachment J and this STC, subject to the restrictions described below, including STC 7. HRSN will be delivered by social service providers in

cooperation with Social Care Networks (SCN), which are contracted entities in each of the state's nine regions that will provide HRSN screening and referral services to otherwise eligible Medicaid beneficiaries that are targeted populations for HRSN services. Expenditures are limited to expenditures for items and services not otherwise covered under title XIX, but consistent with Medicaid demonstration objectives that enable the state to continue to increase the efficiency and quality of care. HRSN services must be clinically appropriate for the beneficiary and based on medical appropriateness using clinical and other health related-social needs criteria; such HRSN services must have a reasonable expectation of improving or maintaining the health or overall function of the beneficiary. The state is required to align clinical and health-related social criteria across services and with other non-Medicaid social support agencies, to the extent possible. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to the beneficiary through local, state, or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services at any time; and the HRSN services do not absolve the state or its managed care plans of their responsibilities to provide required coverage for other medically necessary services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on receipt of HRSN services. The state must submit additional details on covered services as outlined in STC 6.8 (Service Delivery) and Attachment J.

6.2. **Allowable HRSN Services.** The state may cover the following HRSN services:

a. Housing supports, including:

i. Medically necessary air conditioners, humidifiers, air filtration devices and asthma remediation, and refrigeration units as needed for medical treatment.

ii. Medically necessary home modifications and remediation services such as accessibility ramps, handrails, grab bars, repairing or improving ventilation systems, and mold/pest remediation.

iii. Recuperative care and short-term pre-procedure and post-hospitalization housing for individuals experiencing homelessness, or involving a lower-intensity care setting for individuals who would otherwise lack a safe option for discharge or recovery or who would require a hospital stay. Additional requirements for this service are listed in STC 6.3.

iv. Rent/ temporary housing for up to 6 months for the demonstration period. Limited to individuals transitioning out of institutional care/congregate settings or individuals who are homeless, such as nursing facilities, large group homes, congregate residential settings, IMDs, correctional facilities, and acute care hospitals; individuals who are Medicaid high utilizers who are homeless as defined by 24 CFR 91.5; and youth transitioning out of the child welfare system including foster care.

1. Utility costs for individuals receiving rent/temporary housing, for up to 6 months for the demonstration period, including activation expenses and back payments to secure utilities, limited to individuals receiving rent/temporary housing as described in STC 6.2(a)(iv).

v. Pre-tenancy services.

1. Assistance with navigating the complexities of the housing application process through the progression of prospective tenant to tenant such as supporting the beneficiary when undergoing tenant screening, completing rental applications, negotiating lease agreements, and preparing for and attending tenant interviews.
2. Assistance with the housing search and application process, including contacting prospective housing options for availability and information, as well as researching the availability of rental assistance.

vi. Tenancy sustaining services, including tenant rights education and eviction prevention.

1. Assistance in linking beneficiaries to free or affordable legal services for beneficiaries facing housing-related issues.
2. Connecting the individual to available resources to assist in establishing a bank account and bill paying.
3. Assistance in connecting the individual with social services to assist with filling out applications and appropriate documentation in order to obtain sources of income necessary for community living, establishing credit, and in understanding and meeting the obligations of tenancy.
4. Assistance in addressing circumstances and/or behaviors that may jeopardize housing. This should include both direct interventions to address risks and connection of the beneficiary to relevant community resources that may offer assistance.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
6. Assistance with housing recertification processes, including lease renewals and housing subsidy renewals.

vii. Housing transition navigation services, including:

1. One-time transition and moving costs (e.g., security deposit, first month's rent, brokerage fees, utility activation fees, movers, relocation expenses, pest eradication, inspection fees, pantry stocking, and the purchase of household goods and furniture).

2. Assistance with the set-up of the new housing unit, to address needs identified in the person-centered care plan, including clinically appropriate residential modifications to allow the beneficiary to move in, and identify needs for assistance with arranging the move and supporting the details of the move, as appropriate.
3. Connecting the individual to resources aiding with housing costs and other expenses, including linkages to rental assistance vouchers, security deposits, application fees, moving costs, non-medical transportation to tour units and attend tenant interviews, furnishings, adaptive aids, environmental modifications, and food and clothing needed at transition, and other related expenses.
4. Providing a review of the living environment to ensure that it meets the clinical needs of the individual and appropriately supports his/her medical needs and is ready for move-in, including collaboration with relevant provider staff of where the individual is institutionalized (e.g., hospital or facility social worker) to ensure a seamless transition to the community.

b. Case Management:

i. Level One Case Management: Linkages to existing local, state, and federal benefits and programs, outside of the 1115 demonstration HRSN services.

ii. Level Two Case Management: Case management, outreach, and education including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees. Connections to providers, MCOs, crisis services, and behavioral health services. Connections to employment, education, childcare, legal assistance, and interpersonal violence resources. Follow up after services and linkages which includes follow-up after services which includes linkages to additional services that are existing state/federal/local-funded services, if needed.

c. Nutrition Supports:

i. Nutrition counseling and education for members, including on healthy meal preparation and connecting the individual with grocery budget resources.

ii. Up to 3 prepared meals a day, delivered to the home or private residence, for up to 6 months. Meals will be approved by a registered dietician nutritionist (RDN). Must have a health or medical condition that would benefit from medically tailored meals. Meals are either medically tailored, or clinically appropriate, depending on the individual needs of the beneficiary. High-risk pregnant individuals may receive up to 11 months but not to exceed up to 2 months postpartum in meals. Additional meal support is permitted when

provided to the household of a child identified as high risk or pregnant individual, as defined in the risk and needs-based criteria in Attachment J. Beneficiaries who receive delivered meals cannot also receive pantry stocking or nutrition prescriptions.

iii. Medically tailored or nutritionally-appropriate food prescriptions (e.g., fruit and vegetable prescriptions, protein box), delivered in various forms such as nutrition vouchers and food boxes, for up to 6 months. High-risk pregnant individuals may receive up to 11 months but not to exceed up to 2 months postpartum in food prescriptions. Additional support is permitted when provided to the household of a child identified as high risk or pregnant individual, as defined in the risk and needs-based criteria in Attachment J. Beneficiaries who receive delivered food prescriptions cannot also receive pantry stocking or meals.

iv. Fresh produce and nonperishable groceries, for up to 6 months. Limited to pregnant persons and children as defined in Attachment J. High-risk pregnant individuals may receive up to 11 months but not to exceed up to 2 months postpartum in groceries. Additional support is permitted when provided to the household of a child identified as high risk or pregnant individual, as defined in the risk and needs-based criteria in Attachment J. Beneficiaries who receive delivered food prescriptions cannot also receive pantry stocking or meals.

v. Up to 3 prepared meals a day, delivered to the home or private residence, medically tailored or nutritionally-appropriate food prescriptions, or fresh produce and nonperishable groceries may be renewed for additional 6-month periods if a follow up assessment, as provided in STCs 6.6 and 6.7, and the HRSN Protocol at Attachment K, determines the beneficiary still meets the clinical and needs-based criteria. The requirements pertaining to each of these services in STCs 6.2 c.ii.-iv. still apply to renewed services.

d. Cooking supplies that are necessary for meal preparation and nutritional welfare of a beneficiary when not available through other programs (e.g., pots and pans, utensils, microwave, refrigerator).

e. Private and public transportation to transport members to covered HRSN services and case management activities.

6.3. Recuperative Care and Short-Term Pre-procedure and Post-Hospitalization Care

a. Recuperative care and short-term post hospitalization housing settings provide a safe and stable place for eligible individuals transitioning out of institutions, and who are at risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits (as determined by a provider at the

plan or network level), to receive treatment on a short-term basis. Pre-procedure housing is for individuals that are experiencing homelessness and are scheduled for surgery that has been indicated as needing preparation or pre-surgical care by a medical professional. Eligible settings for recuperative care and short-term pre-procedure and post hospitalization housing must have clinicians who can provide appropriate medical and/or behavioral health care. Short-term pre-procedure and post hospitalization housing settings must also offer transitional supports to help enrollees secure stable housing and avoid future readmissions. Recuperative care may be offered for up to ninety (90) days in duration once every 12 months (assessed on a rolling basis). The combination of pre-procedure and post-hospitalization housing may not exceed 6 months, once every 12 months. Pre-procedure stays are limited to a clinically appropriate amount of time. Electing organizations will implement recuperative care, pre-procedure care, and short-term post-hospitalization housing in accordance with the detailed service definitions, standards and requirements in Attachment J.

b. The HRSN Services Protocol, described in STC 6.7, must include a description of the state's documented process to authorize Recuperative Care and Short-Term Pre-procedure and Post Hospitalization Housing Service for beneficiaries for whom there is an assessed risk of a need for other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits. This process must document that a provider using their professional judgement has determined it to be medically appropriate for the specific beneficiary as provision of the Recuperative Care, Short-Term Pre-procedure, and Post Hospitalization Housing Service is likely to reduce or prevent the need for acute care or other Medicaid services. This documentation could be included in a care plan developed for the beneficiary. In addition to this clinical documentation requirement, states may also impose additional provider qualifications or other limitations and protocols, and these must be documented within the managed care plan contracts, HRSN Services Protocol, and state guidance.

c. Eligible settings for recuperative care, short-term pre-procedure, and post-hospitalization housing must have appropriate clinicians who can provide medical and/or behavioral health care. The facility cannot be primarily used for room and board without the necessary additional recuperative support services. For example, a hotel room in a commercial hotel, where there are no medical or behavioral health supports provided onsite appropriate to the level of need, would not be considered an appropriate setting, but if a hotel had been converted to a recuperative care facility with appropriate clinical supports, then it would be an eligible setting.

6.4. **HRSN Infrastructure.**

a. The state may claim FFP in infrastructure investments in order to support the development and implementation of HRSN services, subject to Section 6.1. This FFP will be available for the following activities:

i. Technology – e.g., electronic referral systems, shared data platforms, electronic health record (EHR) modifications or integrations, screening tool and/or case management systems, databases/data warehouses, interoperability with the State Health Information Network for New York, information security, data analytics and reporting, data protections and privacy, accounting and billing systems.

ii. Development of business or operational practices, including Social Care Network administration – e.g., procurement and planning, screening and referral processes, capacity building for social service providers and network development, developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, member navigation.

iii. Workforce development – e.g., cultural competency training, trauma-informed training, traditional health worker certification, training staff on new policies and procedures.

iv. Outreach, education, and stakeholder convening – e.g., design and production of outreach and education materials, translation, obtaining community input, investments in stakeholder convening.

b. The state may claim FFP in HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 8. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 8. Annual Limits of Total Computable Expenditures for HRSN Infrastructure

	DY 25	DY26	DY 27	DY 28	Total
Total Computable Expenditures	$0	$260M	$190M	$50M	$500M

c. Infrastructure investments will receive the applicable administrative match for the expenditure.

d. This infrastructure funding is separate and distinct from the payment to the applicable managed care plans for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures described in STC 6.4 are not factored into managed care capitation payments, and that there is no duplication of funds.

e. The state may not claim any FFP in HRSN infrastructure expenditures until the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualification is approved, as described in STC 6.6. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval date.

f. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

6.5. **Excluded HRSN Services**. Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

a. Construction costs (bricks and mortar) except as needed for approved medically necessary home modifications as described in STC 6.2(a)(ii).

b. Capital investments;

c. Room and board outside of specifically enumerated care or housing transitions or beyond 6 months, except as specified in STC 6.1 and 6.3;

d. Research grants and expenditures not related to monitoring and evaluation;

e. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting;

f. Services provided to individuals who are not lawfully present in the United States or are undocumented;

g. Expenditures that supplant services and activities funded by other state and federal governmental entities;

h. School based programs for children that supplant Medicaid state plan programs, or that are funded under the Department of Education or state, and the local education agency;

i. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

j. Any other projects or activities not specifically approved by CMS as qualifying for demonstration coverage as a HRSN item or service under this demonstration.

6.6. **Covered Populations.** Expenditures for HRSN services may be made for the targeted populations specified below, consistent with this STC. To receive HRSN services, individuals in the target populations must have a documented medical need for the services and the services must be determined medically appropriate, as described in the HRSN Services Section in STC 6.2, for the documented need. Medical appropriateness must be based on clinical and health-related social risk factors, including whether the service would have a reasonable expectation of improving maintaining the health or overall function of the beneficiary. This determination must be documented in the beneficiary's care plan or medical record. Additional detail on targeted populations, including the clinical and other health related-social needs criteria, is outlined in Attachment J.

a. **Populations Eligible for Level One Services.** Level One Services includes screening and Level One Case Management. If a member does not meet the criteria for Level Two HRSN services, then they will receive navigation to state, federal, and local programs outside of the 1115 demonstration to address their HRSN needs. Beneficiaries may be in either fee-for-service or managed care and receive this service.

b. **Populations Eligible for Level Two Services.** Level Two services include Level Two Case Management, and all HRSN Housing, Nutrition, and Transportation Services. Beneficiaries must be enrolled in Medicaid Managed Care and meet one or more of the following criteria, plus be individually assessed for medically needing services per STC 6.6 above:

i. Medicaid high utilizers (defined by Emergency Department, Inpatient, or Medicaid spend, or transitioning from an institutional setting), including those who meet the Department of Housing and Urban Development's definition of homeless as defined by 24 CFR 91.5;

ii. Individuals enrolled in a New York State designated Health Home which currently includes individuals with HIV/AIDS, Sickle Cell Disease, Serious Mental Illness, Substance Use Disorder, Serious Emotional Disturbance, Complex Trauma, or two or more chronic conditions (e.g., Diabetes and Chronic Obstructive Pulmonary Disease);

iii. Individuals with SUD;

iv. Individuals with SMI;

v. Individuals with Intellectual and Developmental Disabilities;

vi. Pregnant persons, up to 12 months postpartum;

vii. Post-release criminal justice-involved population with serious chronic conditions, SUD, or chronic Hepatitis-C;

viii. Juvenile justice involved youth, foster care youth, and those under kinship care.

ix. Children under the age of six; and

x. Children under the age of 18 with one or more chronic condition.

6.7. **Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services.** The state must submit, for CMS approval, a Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications to CMS no later than 90 days after approval of these authorities. The protocol(s) must include, as appropriate, a list of the HRSN services and service descriptions, the criteria for defining a medically appropriate population for each service, the process by which that criteria will be applied including care plan requirements or other documented processes, proposed uses of HRSN infrastructure funds, and provider qualification criteria for each service. Each protocol may be submitted and approved separately. The state must resubmit an updated protocol, as required by CMS feedback on the initial submission. The protocol may be updated as details are changed or added. The state may not claim FFP in HRSN services or HRSN infrastructure expenditures until CMS approves the associated protocol, except as otherwise provided herein. Once the associated protocol is approved, the state can claim FFP in HRSN services and HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval date. The approved protocol(s) will be appended to the STCs as Attachment K.

Specifically, the protocol must include the following information:

a. Proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.

b. A list of the covered HRSN services (not to exceed those allowed under STC 6.2), with associated service descriptions and service-specific provider qualification requirements.

c. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary eligibility, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.

d. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may deem the service to be medically appropriate.

    i. Plan to identify medical appropriateness based on clinical and social risk factors.

    ii. Plan to publicly maintain these clinical/social risk criteria to ensure transparency for beneficiaries and stakeholders.

e. A description of the process for developing care plans based on assessment of need.

    i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening.

    ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma-informed.

f. Plan to avoid duplication/ displacement of existing food assistance/nutrition services including how the state will prioritize and wrap around SNAP and/or WIC enrollment, appropriately adjust Medicaid benefits for individuals also receiving SNAP and/or WIC services, and ensure eligible beneficiaries are enrolled to receive SNAP and/or WIC services.

g. An affirmation that the state agrees to meet the enhanced monitoring and evaluation requirements stipulated in STC 14.7.b.ii and STC 17.6.a which require the state to monitor and evaluate how the renewals of recurring nutrition services in STC 6.2.c.v affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services. As required in STC 14.6 and STC 17.3, the monitoring protocol and evaluation design are subject to CMS approval.

6.8. **Service Delivery:** HRSN services will be primarily provided in the managed care delivery system with limited case management services being provided in the FFS delivery system. As outlined in STC 6.1, HRSN services will be delivered by HRSN service providers in cooperation with SCNs. Terms applicable to all HRSN Services:

a. HRSN screening and HRSN 1115 Level One Case Management services will be paid on a FFS basis when those HRSN services are provided to beneficiaries enrolled in Medicaid FFS.

b. When HRSN services are provided to beneficiaries enrolled in Medicaid managed care, the SCNs will be contracted providers with the managed care plans. The following terms will also apply:

i. As of April 1, 2024, HRSN Services will be provided as a non-risk basis in Medicaid managed care. For a non-risk payment, the MCO is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR 447.362 and may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. For the purposes of this demonstration, fee-for-service as defined in 42 CFR 447.362 is the fee-for-service authorized in this demonstration for HRSN Services paid on a fee-for-service basis by the state. The managed care plan contracts must clearly document the process and methodology for non-risk payments.

ii. No later than April 1, 2027, the state will incorporate the HRSN Services into the risk-based capitation rates in Medicaid managed care, and must comply with all applicable Federal requirements, including but not limited to 42 CFR 438.4, 438.5, 438.6, and 438.7, and the state may no longer utilize non-risk payments.

iii. Any applicable HRSN 1115 services that are delivered by managed care plans in a risk arrangement, must be included in the managed care contracts and rate certifications submitted to CMS for review and approval in accordance with 42 CFR 438.3(a) and 438.7(a). The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on the inclusion of HRSN services in managed care programs.

iv. When HRSN (i.e., HRSN services defined in STC 6.1 for the covered populations outlined in STC 6.6) is included in capitation rates to managed care plans under risk-based contracts, and only then, HRSN services should be reported in the medical loss ratio (MLR) reporting as incurred claims. The state must develop an MLR monitoring and oversight process specific to HRSN services. This process must be submitted to CMS, for review and approval, no later than 6 months prior to the implementation of HRSN services in risk-based managed care contracts and capitation rates. The state should submit this process to CMS at DMCPMLR@cms.hhs.gov. This process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs and infrastructure will be identified and reported in the MLR as non-claims costs.

c. In accordance with STC 6.14, CMS expects the state to have appropriate encounter data associated with each HRSN service. This is necessary to ensure appropriate fiscal oversight for HRSN services as well as monitoring and evaluation. This is also critical to ensure appropriate base data for Medicaid managed care rate development purposes as well as appropriate documentation for claims payment in both managed care and FFS. Therefore, CMS requires that for HRSN services provided in a managed care delivery system, the state must include the name and

definition of each HRSN service as well as the coding to be used on claims and encounter data in the managed care plan contracts. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology costs that identify each HRSN service. Additionally, for HRSN services provided in an FFS delivery system, this information must be clearly documented for Social Care Networks. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 6.15.

d. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on the inclusion of HRSN services in managed care programs and in FFS.

6.9. **Contracted Providers**. Consistent with the managed care contract and applicable to all HRSN services:

a. Managed care plans will contract with SCNs ("Contracted Providers") to deliver the elected HRSN services authorized under the demonstration.

b. SCNs must establish a network of providers and ensure the Social Service Providers have sufficient experience and training in the provision of the HRSN services being offered. Social Service Providers do not need to be licensed, however, staff offering services through Social Service Providers must be licensed when appropriate and applicable.

c. The managed care plan and SCN will use rates set by the state for the provision of applicable HRSN services, consistent with state guidance for these services, and in compliance with all related federal requirements.

i. Any state direction of managed care plan expenditures under risk-based contract(s) and risk-based payments would only be considered a state directed payment subject to the requirements in 42 CFR 438.6(c).

6.10. **Provider Network Capacity.** Managed care plans must ensure the HRSN services authorized under the demonstration are provided to eligible beneficiaries in a timely manner, and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the HRSN services, in accordance with the managed care plan contracts and other state Medicaid/operating agency guidance.

6.11. **Compliance with Federal Requirements.** The state shall ensure HRSN services are delivered in accordance with all applicable federal statute, regulation or guidance.

6.12. **Person Centered Plan.** The state shall ensure there is a person-centered service plan for each individual receiving HRSN services that is person-centered, identifies the member's

needs and individualized strategies and interventions for meeting those needs, and be developed in consultation with the member and the member's chosen support network as appropriate. The service plan is reviewed and revised at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

6.13. **Conflict of Interest**. The state shall ensure appropriate protections against conflicts of interest in the service planning. The state also agrees that appropriate separation of service planning and service provision functions are incorporated into the state conflict of interest policies.

6.14. **CMS Approval of Managed Care Contracts.** As part of the state's submission of associated Medicaid managed care plan contracts to implement HRSN services through managed care, the state must include contract requirements including, but not limited to:

a. Beneficiary and plan protections, including but not limited to:

i. HRSN services must not be used to reduce, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid covered services.

ii. Medicaid beneficiaries always retain their right to receive the Medicaid covered service on the same terms as would apply if HRSN services were not an option.

iv. Medicaid beneficiaries who are offered or utilized an HRSN retain all rights and protections afforded under 42 CFR 438.

v. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that they are currently receiving HRSN services, have requested those services, or have previously received these services.

vi. Managed care plans are prohibited from requiring a beneficiary to utilize HRSN services.

b. Managed care plans must timely submit data requested by the state or CMS, including, but not limited to:

i. Data to evaluate the utilization and effectiveness of the HRSN services.

ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identify), race, ethnicity, disability status and preferred language to inform health quality improvement efforts, which may thereby mitigate health disparities.

iii. Any data necessary to monitor appeals and grievances for beneficiaries.

iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services.

v. Any data determined necessary by the state or CMS to monitor and oversee the HRSN initiatives.

c. All data and related documentation necessary to monitor and evaluate the HRSN services initiatives, including cost assessment, to include but not limited to:

i. The managed care plans must submit timely and accurate encounter data to the state for beneficiaries eligible for HRSN services. When possible, this encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts and subsequent efforts to mitigate health disparities undertaken by the state.

ii. Any additional information requested by CMS, the state or legally authorized oversight body to aid in on-going evaluation of the HRSN services or any independent assessment or analysis conducted by the state, CMS, or a legally authorized independent entity.

iii. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports its progress in building and sustaining its partnership with existing housing agencies and nutrition agencies to utilize their expertise and existing housing resources and avoid duplication of efforts.

iv. Any additional information determined reasonable, appropriate and necessary by CMS.

6.15. **HRSN Rate Methodologies.** All rate and/or payment methodologies for authorized HRSN services outlined in these STCs must be submitted to CMS for review and approval prior to implementation, including but not limited to FFS payment, as well as non-risk payments, state directed payment preprints, and capitation rates in managed care delivery systems, as part of the HRSN Implementation Plan (see STC 6.19) at least 60 days prior to implementation. The state must submit all documentation requested by CMS, including but not limited to the payment rate methodology (or methodologies) as well as other documentation and supporting information (e.g., state responses to Medicaid non-federal share financing questions). The state must also notify CMS if they intend to direct their managed care plans on how to pay for HRSN services at least 60 days prior to implementation.

6.16. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding for ongoing social services related to the categories of housing transition supports and

nutrition supports comparable to those authorized under this demonstration, for the populations authorized under this demonstration**,** and for the duration of this demonstration, not including one time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the HRSN Implementation Plan that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.7, with any justifications, including declines in available state resources, necessary to describe the findings, if the level of state funding is less than the comparable amount of the pre-demonstration baseline.

6.17. **Partnerships with State and Local Entities.** The state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authority, Supplemental Nutrition Assistance Program (SNAP) state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the care plans as appropriate. The state will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing and nutrition supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 14.7, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.

6.18. **Provider Payment Rate Increase.** As a condition of the HRSN services and infrastructure expenditure authorities, New York must comply with the provider rate increase requirements in Section 7 of the STCs.

6.19. **HRSN Implementation Plan**

a. The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs. The Implementation Plan can be updated as initiatives are changed or added. CMS will provide a template to support this reporting that the state will be required to use to help structure the information provided and prompt the state for information CMS would find helpful in approving the Implementation Plan. The state must submit the MOE information required by STC 6.16 for CMS approval no later than 90 calendar days after approval of this demonstration. All other Implementation Plan

requirements outlined in this STC must be submitted for CMS approval no later than 9 months after the approval of this demonstration. Once approved, the Implementation Plan will be appended as Attachment J and, once appended, may be altered only with CMS approval.

b. At a minimum, the Implementation Plan must provide a description of the state's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services; however, as applicable, the information provided in the two deliverables must be aligned and consistent with one another.

c. The Implementation Plan must include information on, but not limited to, the following:

    i. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services stakeholders to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation;

    ii. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries);

    iii. Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, eligibility and consent, screening, referrals, and service provision;

    iv. A plan for tracking and improving the share of Medicaid beneficiaries in the state who are eligible and enrolled in the SNAP, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), and federal and state housing assistance programs, relative to the number of total eligible beneficiaries in the state;

    v. An implementation timeline and evaluation considerations impacted by the timeline, such as staged rollout, that can facilitate robust evaluation designs;

vi. Information as required per STC 6.15 (HRSN Rate Methodologies);

vii. Information as required per STC 6.16 (MOE); and

viii. Information as required per STC 6.17 (Partnerships with State and Local Entities).

d. Failure to submit the Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of authority for HRSN Infrastructure and HRSN Services, under this demonstration.

7. PROVIDER RATE INCREASE REQUIREMENTS

7.1. The provider payment rate increase requirements described hereafter are a condition for the DSHP, Health Equity Initiative, and HRSN expenditure authorities, as referenced in expenditure authorities #8-13. CMS considers the combination of the following initiatives— Medicaid Hospital Global Budget Initiative Authority, HRSN, Workforce Initiatives, and HERO— to constitute a Health Equity Initiative.

7.2. As a condition of approval and ongoing provision of FFP for the DSHP, Equity Initiative, and HRSN expenditures over this demonstration period of performance, DY 24 through DY 28, the state will in accordance with these STCs increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates, by at least two percentage points in the ratio of Medicaid to Medicare provider rates for one of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent. New York is also required to invest $199,072,125 (total computable) in rate increases as part of the demonstration amendment, which must be sustained by the state once implemented. This requirement is applicable even if no Medicaid rates are below 80 percent of Medicare rates. The state may make the rate increases in any demonstration year, but the net provider rate increases must amount to $199,072,125 by the end of the demonstration period.

7.3. The state may not decrease provider payment rates for other Medicaid or demonstration covered services to make state funds available to finance provider rate increases required under this STC (i.e., cost-shifting).

7.4. The state will, for the purpose of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increases as may be required under this section 7, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.

7.5. No later than 90 days of the demonstration effective date, and if the state makes fee for service payments, the state must establish and report to CMS the state's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the state and the service category as noted in the following sources:

i. for primary care and obstetric care services in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3); AND

ii. for behavioral health services (the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3)); OR

b. Provide to CMS for approval for any of the three services categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

i. Service codes must be representative of each service category as defined in STC 7.4;

ii. Medicaid and Medicare data must be from the same year and not older than 2019.

iii. The state's methodology for selecting the year of data, determining Medicaid code-level utilization, the service codes within the category, geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data

and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

7.6. To establish the state's ratio for each service category identified in STC 7.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

a. The average fee-for-service ratio as provided in STC 7.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the State pay providers based on state plan fee-for-service payment rate schedules); OR

b. The data and methodology for any or all of the service categories as provided in STC 7.5(b) using Medicaid managed care provider payment rate and utilization data.

7.7. In determining the ratios required under STC 7.5 and 7.6, the state may not incorporate fee-for-service supplemental payments that the State made or plans through March 31, 2027, to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR § 438.6(a) and 438.6(d).

7.8. If the state is required to increase provider payment rates for managed care plans per STC 7.2 and 7.6, the state must:

a. Comply with the requirements for state directed payments in accordance with 42 CFR 438.6(c), as applicable; and

b. Ensure that the entirety of a two-percentage point increase applied to the provider payments rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

7.9. For the entirety of DY 26 through DY 28, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY24, and such rate will be in effect on the first day of DY26. A required payment rate increase shall apply to all services in a service category as defined under STC 7.4.

7.10. If the state uses a managed care delivery system for any of the service categories defined in STC 7.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY 26 through DY 28, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 24 plus an amount necessary so that the Medicaid to Medicare

ratio for that service increases by two percentage points. The payment increase shall apply to all services in a service category as defined under STC 7.4.

7.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of DY 26 (or, as applicable, the first day of the first rating period that starts in DY 26), the State will provide an alternative effective date and rationale for CMS review and approval.

7.12. New York will provide the information to document the payment rate ratio required under STC 7.5 and 7.6, via submission to the Performance Metrics Database and Analytics (PDMA) portal for CMS review and approval.

7.13. For demonstration years following the first year of provider payment rate increases, if any, New York will provide an annual attestation within the State's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, in the previous year.

7.14. No later than 90 days following the demonstration effective date, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to Performance Metrics Database and Analytics (PMDA), along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 7.5 and 7.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment M:

Table 9 - New York HRSN and DSHP Related Provider Payment Increase Assessment – Attestation Table

The reported data and attestations pertain to HRSN, Health Equity Initiative, and DSHP related provider payment increase requirements for the demonstration period of performance DY 25 through DY 28		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-service Ratio**	**Medicaid Managed Care to Medicare Fee-for-service Ratio**
Primary Care Services	[*insert percent, or N/A if state does not make Medicaid fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories*]

	[*insert approach, either ratio derived under STC 7.5(a) or STC 7.5(a)*]	[*insert approach, either ratio derived under STC 7.6(a) or STC 7.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Obstetric Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for providers of covered service categories*]
	[*insert approach, either ratio derived under STC 7.5(a) or STC 7.5(b)*]	[*insert approach, either ratio derived under STC 7.6(a) or STC 7.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Behavioral Health Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]*
	[*insert approach, either ratio derived under STC 7.5(a) or STC 7.5(b)*]	[*insert approach, either ratio derived under STC 7.6(a) or STC 7.6(b)*]; insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
In accordance with STCs 7.1 through 7.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment increases for each service will be effective beginning on [*insert date*] and will not be lower than the highest rate for that service code in DY 24 plus a		

two-percentage point increase relative to the rate for the same or similar Medicare billing code through at least [*insert date*].

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 7.6(b) will be based on Medicaid managed care provider payment rate and utilization data.

[*Select the applicable effective date, must check either a. or b. below*]

☐a. The effective date of the rate increases is the first day of DY [*3, provide the actual year*] and will be at least sustained, if not higher, through DY [*5, provide the actual year*]

☐b. New York has a biennial legislative session that requires provider payment approval, and the timing of that session precludes the state from implementing the payment increase on the first day of DY [*3, provide the actual year*]. New York will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY [*5, provide the accrual year*].

New York [*insert does or does not*] make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, as necessary to comply with the DSHP, Health Equity Initiative, and HRSN STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*]

New York [*insert does or does not*] include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care. For any such payments, as necessary to comply with the DSHP, Health Equity Initiative, and HRSN STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 7.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *[insert date*]
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 7.8, I attest that necessary arrangements will be made to assure that 100 percent of the two-percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
New York further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 7.
I, *[insert name of SMD or CFO (or equivalent position)*] [*insert title*], attest that the above information is complete and accurate. [*Provide signature*_____] [*Provide date*_____] [*Provide printed name of signatory*]

8. SUBSTANCE USE DISORDER (SUD) PROGRAM AND BENEFITS

8.1. **SUD Program Benefits.** Effective upon CMS's approval of the SUD Implementation Plan, the demonstration benefit package for Medicaid beneficiaries will include SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Medicaid beneficiaries who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD services, that would otherwise be matchable if the beneficiary were not residing in an IMD once CMS approves the state's Implementation Plan. The state will aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 14.5, to ensure short-term residential stays.

Under this demonstration beneficiaries will have access to high quality, evidence-based OUD/SUD treatment services across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing chronic care for these conditions in cost-effective community-based settings.

8.2. **SUD Implementation Plan and HIT Plan.**

a. The state must submit the SUD Implementation Plan within ninety (90) calendar days after approval of this demonstration. The state must submit the revised SUD Implementation Plan within sixty (60) days after receipt of CMS's comments. The state may not claim FFP for services provided in IMDs to beneficiaries who are primarily receiving SUD treatment and withdrawal management services until CMS has approved the SUD Implementation Plan. Once approved, the SUD Implementation Plan will be incorporated into the STCs as Attachment H and once incorporated, may be altered only with CMS approval. After approval of the applicable implementation plans required by these STCs, FFP will be available prospectively, not retrospectively.

b. Failure to submit a SUD Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 14.1.

c. At a minimum, the SUD Implementation Plan must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

i. **Access to Critical Levels of Care for OUD and other SUDs.** Coverage of OUD/SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management, within 12-24 months of demonstration approval;

ii. **Use of Evidence-based SUD-specific Patient Placement Criteria.** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of demonstration approval;

iii. **Patient Placement.** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of

care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;

iv. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities.** Currently, residential treatment service providers must meet the requirements specified in Part 820 "Residential Services" of the Codes, Rules, and Regulations of the State of New York, Title 14 Department of Mental Hygiene, Chapter XXI of the Office of Alcoholism and Substance Abuse Services. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

v. **Standards of Care.** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

vi. **Standards of Care.** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;

vii. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OUD.** An assessment of the availability of providers in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of demonstration approval;

viii. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD.** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

ix. **Improved Care Coordination and Transitions between Levels of Care.** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and

supports following stays in these facilities within 24 months of demonstration approval;

x. **SUD HIT Plan.** Implementation of a Substance Use Disorder Health Information Technology Plan which describes technology that will support the aims of the demonstration. Further information which describes milestones and metrics are detailed in STC 8.2.d and Attachment H.

d. **SUD Health Information Technology Plan ("HIT Plan").** The SUD Health information technology (HIT) plan applies to all states where the HIT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003, states must submit to CMS the applicable HIT Plan(s), to be included as a section(s) of the associated Implementation Plan(s) (see STC 8.2.a and 8.2.c), to develop infrastructure and capabilities consistent with the requirements outlined in each demonstration-type.

e. The HIT Plan should describe how technology can support outcomes through care coordination; linkages to public health and prescription drug monitoring programs; establish data and reporting structure to monitor outcomes and support data driven interventions. Such technology should, per 42 CFR 433.112(b), use open interfaces and exposed application programming interfaces and ensure alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator for HIT in accordance with 42 CFR part 170, subpart B.

i. The state must include in its Monitoring Protocol (see STC 14.7[a]) an approach to monitoring its SUD HIT Plan which will include performance metrics to be approved in advance by CMS.

ii. The state must monitor progress, each DY, on the implementation of its SUD HIT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Report (see STC 15.9).

iii. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD HIT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

iv. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or accountable care organization (ACO) participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally recognized standards.

v. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally recognized ISA standards.

vi. Components of the HIT Plan include:

1. The HIT Plan must describe the state's alignment with Section 5042 of the SUPPORT Act requiring Medicaid providers to query a Qualified Prescription Drug Monitoring Program (PDMP)[5].

2. The HIT Plan must address how the state's Qualified PDMP will enhance ease of use for prescribers and other state and federal stakeholders.6 States should favor procurement strategies that incorporate qualified PDMP data into electronic health records as discrete data without added interface costs to Medicaid providers, leveraging existing federal investments in RX Check for Interstate data sharing.

3. The HIT Plan will describe how technology will support substance use disorder prevention and treatment outcomes described by the demonstration.

4. In developing the HIT Plan, states should use the following resources:

a. States may use federal resources available on HIT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and HIT" (https://www.healthit.gov/playbook/health-information-exchange/).

b. States may also use the CMS 1115 HIT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 HIT Toolkit" for HIT considerations in conducting an assessment and developing their HIT Plans.

c. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific HIT infrastructure with regards to PDMP

[5] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.
[6] *Ibid.*

interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

d. States should review the Office of the National Coordinator's Interoperability Standards Advisory (https://www.healthit.giv/isa/) for information on appropriate standards which may not be required per 45 CFR part 170, subpart B for enhanced funding, but still should be considered industry standards per 42 CFR 433.112(b)(12).

8.3. **Unallowable Expenditures Under the SUD Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

9. MEDICAID HOSPITAL GLOBAL BUDGET INITIATIVE

The state is eligible to receive $2.2 billion total computable over 4 years or $550 million annually, contingent on it meeting the requirements below. A key goal of the state is to improve quality of care and promote adoption of alternative payment models that will stabilize finances of certain safety net hospitals and advance accountability and health equity. Under the demonstration, the state is providing financial support to certain hospitals located in Brooklyn, Bronx, Queens, and Westchester Counties in part due to the significant lower health factors and health outcomes in this area.

9.1. **Medicaid Hospital Global Budget Initiative Criteria.** The eligible hospitals must meet the following three criteria:

a. Private Not-For-Profit Hospitals in the Bronx, Kings, Queens, and Westchester Counties with a Medicaid and Uninsured Payor Mix of at least 45 percent;

b. Private Not-For-Profit Hospitals with an average operating margin that is less than or equal to 0 percent over the past four years (Calendar Years 2019-2022) based on audited Hospital Institutional Cost Reports (excluding COVID relief funding and state-only subsidy); and

c. Private Not-For-Profit Hospitals or their affiliates that received state-only subsidies due to financial distress in State Fiscal Years 2023 and/or 2024.

9.2. **Requirements for the Medicaid Hospital Global Budget Initiative.** The state must submit a plan to implement a Medicaid Hospital Global Budget Model. If the state applies

for and is chosen as a participant in the Center for Medicare and Medicaid Innovation (CMMI) model, entitled States Advancing All-Payer Health Equity Approaches and Development (AHEAD) and completes criteria a-e below as part of its participation in the model, it will be deemed to have met this requirement. Nothing in these STCs binds CMS to approve any future proposal from the state. If the state is *not* chosen under a CMMI AHEAD model, it must submit a Medicaid Hospital Global Budget methodology that meets the following requirements:

a. The state must specify the Medicaid services proposed under the hospital global budget;

b. The state must describe its methodology for constructing the hospital global budget, including how any section 1115 demonstration authority provided via the January 2024 amendment through March 31, 2027, will be incorporated into the budget;

c. The state must specify a proposed methodology to determine updates for the budget;

d. The state may propose adjustments similar to adjustments that align with the CMMI AHEAD model hospital global budget methodology for Medicare fee for service; and

e. The state must propose a quality and health equity improvement strategy.

9.3. **Requirements for Funding.** To be eligible for any Medicaid Hospital Global Budget Initiative incentive payments, New York and certain, eligible individual hospitals must complete all of the requirements described below. If a hospital does not submit the required LOI, data, or application for CMMI AHEAD model, or other information specified below by the deadline, it will not be eligible for any future year incentive payments. New York intends to use state general revenue as its source of non-federal share for this initiative.

9.4. **Requirements for DY 0 of Amendment (January 9, 2024 through March 31, 2024).** The state must submit documentation in its annual monitoring report showing it met the following requirements no later than March 31, 2024.

a. The state must submit an initial Letter of Intent (LOI) and then an application in response to a forthcoming Notice of Funding Opportunity (NOFO) for a CMMI state AHEAD model which will include hospital global budgets and primary care transformation (in either the first or second application period);

b. The state must secure LOIs from eligible hospitals expressing intent to participate in a CMS model or another global payment model. The state must report to CMS in its standard 1115 monitoring reports which eligible hospitals have expressed interest in the model; and

c. The state must submit a detailed plan showing how it and its providers will collect beneficiary-reported demographic and HRSN data[7] and ensure completeness of the data.

9.5. **Requirements for DY 1 of Amendment (April 1, 2024 to March 31, 2025).** The state must submit documentation in its annual monitoring report showing it met the following requirements no later than March 31, 2025.

a. If the state does not apply in the first CMMI AHEAD model application cohort, then the state must apply in the second application cohort of the CMMI AHEAD model by mid-2024.

b. Each eligible hospital must reconfirm via an LOI that it will participate in the hospital global budget as a part of the CMMI AHEAD model. The state will submit documentation, in collaboration with participating hospitals, showing that they are on track for developing a Medicaid global payment methodology effective April 1, 2027 (the start of the next 1115 extension period).

c. If the state and its eligible hospitals do not participate in the CMMI AHEAD model, the state must submit a proposal to CMS that includes details on an alternative Medicaid-only hospital global budget model to launch in the state as of April 1, 2027 (the start of the next 1115 extension period).

d. Each participating hospital that receives Medicaid Hospital Global Budget Initiative incentive payments must submit a health equity plan to the state. These plans must be aligned with the statewide health equity plan described in (h) below.

e. Each participating hospital must submit complete quality data on quality metrics to be specified in the state's post-approval Medicaid Hospital Global Budget Initiative to Medicaid Hospital Global Budget Initiative Implementation Protocol, appended to these STC once approved by CMS as Attachment L. The quality metrics should align to the extent reasonable to CMS's Disparities-Sensitive Measure Set.

f. The state must confirm in the demonstration monitoring reports that each participating hospital submitted a common fact base for their health system to the state, including information such as:

i. Key statistics on population served, degree of patient engagement/ satisfaction;

ii. Competitive landscape, including payor/provider and regulatory impacts;

[7] Demographic and HRSN data should include all of the following categories: race, ethnicity, primary language, disability status, sexual orientation, gender identity, and health-related social needs.

iii. Overview of current financial performance and payment models;

iv. Evaluation of IT infrastructure, interoperability capabilities, data infrastructure, and reporting and analytics capabilities;

v. Evaluation of physical plant infrastructure and necessary capital investments to support population health;

vi. Assessment of historical/projected operating expenses with specific focus on variable and non-variable expenses; and

vii. Opportunities for Quality Improvement.

g. Each participating hospital must submit a custom roadmap to the state of key targeted activities required to transition to a global budget model, including considerations on where to invest versus build, required partnerships, talent change management, and technology gaps. The state must confirm submission in the demonstration monitoring reports.

h. The state must develop an Implementation Plan that describes how it will develop a robust health equity plan to identify underserved communities and implement initiatives to measurably reduce health disparities within their beneficiary populations and prepare for statewide quality/equity measurements, appended to these STC once approved by CMS as Attachment L. The state must include the quality/ equity measures selected for hospital-level reporting and performance, which must include Pay for Performance (P4P) quality measures. The quality metrics should align to the extent reasonable to CMS's Disparities-Sensitive Measure Set. The state will identify baseline data, adequacy, and needs in communities as part of this plan. This plan must be submitted to CMS prior to April 1, 2025, and will be appended to these STCs as Attachment L once approved by CMS.

9.6. **Requirements for DY 2 of Amendment (April 1, 2025 through March 31, 2026).** The state must submit documentation in its annual monitoring report showing it met the following requirements no later than March 31, 2026 or sooner, as otherwise specified below.

a. Each hospital must submit quality measures approved in the Implementation Protocol described in STC 9.5(e);

b. Each hospital must execute key milestones on their state-approved roadmap in at least the following areas:

i. Data, interoperability, analytics, and reporting;

ii. Financial modeling;

iii. Care coordination and management;

iv. Quality improvement;

v. Compliance and business operations;

vi. Network and physician engagement;

vii. Patient experience and engagement;

viii. Opportunities for Service Line Rationalization based on community need; and

ix. Leadership, governance, and talent change management.

c. The state must provide updates regarding its statewide health equity plan in the annual monitoring reports.

d. The state must submit its plan and methodology for a Medicaid hospital global budget 18 months prior to the expiration of the current demonstration period or by September 30, 2025.

e. The state must submit an updated plan regarding its methodology for a Medicaid hospital global budget as part of its 1115 extension request due March 31, 2026.

9.7. **Requirements for DY 3 of Amendment (April 1, 2026 through March 31, 2027).** The state must submit documentation showing in its annual monitoring report it met the following requirements no later than March 31, 2027.

a. The state must work collaboratively with all components of CMS to achieve the proper Medicaid authorities to launch a Medicaid hospital global budget as of April 1, 2027.

b. Each hospital must provide a progress report and, where appropriate, provide updates to their state-approved transformation roadmap to the state for approval.

The state must provide updates regarding its statewide health equity plan in the annual monitoring reports.

c. The state and hospitals must submit achievement on the Initiative's incentive metrics, including readiness to adopt global payment methodologies, as well as any funding forfeited by the state or hospitals due to a lack of performance. The state must provide achievement updates in the demonstration monitoring reports.

9.8. **Medicaid Hospital Global Budget Initiative Funding by Demonstration Year.** Below is a chart that specifies the funding for each year of the demonstration. The funding may roll over to the next year.

Table 10: Medicaid Hospital Global Budget Initiative

	DY 25	DY 26	DY 27	DY 28	Total
	01/09/2024 to 03/31/2024	04/01/2024 to 03/31/2025	04/01/2025 to 03/31/2026	04/01/2026 to 03/31/2027	
Total Computable Expenditures	$550M	$550M	$550M	$550M	$2.2B

9.9. **Budget Neutrality Treatment for Medicaid Hospital Global Budget Initiative.** The expenditure authority for the Medicaid Hospital Global Budget Initiative must be supported out of budget neutrality savings.

9.10. **Federal Matching Rate for Medicaid Hospital Global Budget Initiative.** All expenditures for the Medicaid Hospital Global Budget Initiative must be claimed as administrative on the applicable CMS 64.10 waiver form(s). The state must ensure that Medicaid Hospital Global Budget Initiative incentive expenditures described in STC 9 are not factored into managed care capitation payments, and that there is no duplication of funds.

9.11. **Medicaid Hospital Global Budget Initiative Incentive Payments.** Incentive payments under the Medicaid Hospital Global Budget Initiative are not direct reimbursement for expenditures or payments for services. Incentive payments under the Medicaid Hospital Global Budget Initiative shall not be considered patient care revenue and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care.

10. DELIVERY SYSTEMS

10.1. **Contracts**. Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index that shall be rebased based on actual documented costs no less than every two years).

10.2. **Managed Care Contracts**. No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of model contract language. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 45 days to review and approve changes. CMS reserves the right, as a corrective action,

to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

10.3. **Compliance with Managed Care Requirements**. The state must meet the requirements of 4242 CFR part 438 unless a requirement of part 438 has been identified in the waiver authorities as expressly waived or specified as not applicable to an expenditure authority for this demonstration.

10.4. **Interpretation Services and Culturally Competent Care**. The MCOs and other entities acting on behalf of the state Medicaid agency, including, but not limited to enrollment brokers, must have interpretation services and provide care that is consistent with the individual's culture. MCOs must conduct analyses to determine any gaps in access to these services and will expand its workforce accordingly. The MCOs may also require the use of remote video and voice technology when necessary.

10.5. **Marketing Oversight.**

a. The state shall require each MCO to meet 42 CFR 438.104 and state marketing guidelines regarding prohibition of cold calls, use of government logos, and other standards.

b. All materials used to market the MCO shall receive prior approval from the state.

c. The state shall require through its contracts that each MCO provide all individuals who were not referred to the plan by the enrollment broker with information (in a format determined by the state) describing managed long-term care, a list of available plans and contact information to reach the enrollment broker for questions or other assistance.

10.6. **Managed Care Benefit Packages.** Individuals enrolled in managed care plans under the demonstration must receive from the managed care program the benefits as identified in Attachments A through D. As noted in plan readiness and contract requirements, the state must require that, for enrollees in receipt of LTSS, each MCO/ prepaid inpatient health plan (PIHP) coordinate, as appropriate, needs state plan services that are excluded from the managed care delivery system but available through a fee-for-service delivery system, and must also assure coordination with services not included in the established benefit package. Plans will be at risk for any Medicaid covered service that is currently delivered. BH HCBS in HARPs and HIV SNPs will be non-risk for the initial years in accordance with STC 5.2. If the MCO network is unable to provide necessary medical services covered under the contract to a particular enrollee, the MCO will be required to cover these services out of network for the enrollee. The costs of room and board may not be covered and cannot be included when determining the MCO payment rates.

10.7. **Managed Care Rates Transition for HARPs**. While working towards a managed care capitated rate for HARPs, the state may not proceed with implementation in a region until it has approved HCBS fee for service rates for such region. The state must submit HARP capitation rates to CMS for approval no later than December 31, 2017. Should the state not have the ability to submit proposed rates, it must request a temporary extension to continue using the most recently approved rates.

10.8. **Managed Care Rate Transition for Nursing Facilities (NF).** As of February 1, 2015, plans are required to pay contracted nursing homes either the existing FFS rate or a negotiated rate which allows the nursing home and the plan to engage in other financing arrangements. MLTC and MMMC plans will be reimbursed with an actuarial sound rate in compliance with 42 CFR § 438.44. MLTC will develop a blended rate structure to promote community integration of institutional/HCBS. MMMC will develop a separate rate cell for the nursing home population and will include an HCBS "rate cohort" in its non-nursing home rate cells. The state shall submit an actuarial certification to CMS for approval of the April 1, 2015 rates that contains the following modifications:

a. MLTC transition rates must be phased out;

b. Documentation must be submitted identifying the unique and cumulative impact of the various capitation rate withholds;

c. Documentation must be submitted assessing gaps in rate setting for MLTC plans that necessitate funds to mitigate risks.

10.9. **Behavioral Health Services Furnished by MMMC, HIV SNPs, and HARPs.** To the extent that an MCO is not able to meet the requirements for the management of the expanded behavioral health services, the MCO must contract with a managed care behavioral health organization to manage those services for enrollees. If the MCO network is unable to provide necessary medical services covered under the contract to a particular enrollee, the MCO will be required to cover these services out of network for the enrollee. This includes up to at least 2023 during which time the MCO will reimburse OMH ambulatory licensed and OASAS certified providers the FFS fee schedule to ensure continuity of care. MCOs must pay at least the FFS fee schedule for 24 months for the following services: Other Licensed Practitioner (OLP), Crisis Intervention, Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), and Family and Youth Peer Support. After 90 days, the MCO may apply utilization review criteria to individuals under the care of non-participating providers. Plans will be required to authorize services and reimburse providers whether the behavioral health provider is contracted with the health plans or is an out of network provider. New York will reimburse MCOs for VFCA per diem/Preventive Residential Treatment Services on a non-risk basis subject to the non-risk UPL at 42 CFR 447.362. The MCO must pay the FFS fee schedule as long as the Preventive Residential Treatment Services are non-risk.

a. For SUD services and the delivery system changes associated with the new demonstration services and resulting state plan amendments including changes under the CMS Innovation Accelerator Program (IAP) and with CMS approval, the state may require the MCOs through their contracts to adopt system-wide changes and rates to ensure that the innovations are adopted in a consistent manner statewide.

10.10. **Independent Consumer Support Program.** To support the beneficiary's experience receiving and applying to receive long term services and supports in a managed care environment, the state shall create and maintain a permanent independent consumer support program to assist beneficiaries in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights.

10.11. **Organizational Structure.** The Independent Consumer Support Program shall operate independently from any MRT MCO. Additionally, to the extent possible, the program shall also operate independently of the state Medicaid agency.

10.12. **Accessibility.** The services of the Independent Consumer Support Program shall be available to all Medicaid beneficiaries enrolled in MRT who need LTSS (institutional, residential and community based) and must be accessible through multiple entryways (e.g., phone, internet, office) and also provide outreach in the same manner as appropriate.

10.13. **Functions.** The Independent Consumer Support Program shall assist beneficiaries to navigate and access covered LTSS, including the following activities:

a. offer beneficiaries support in the pre-enrollment state, such as unbiased health plan choice counseling and general program-related information;

b. serve as an access point for complaints and concerns about health plan enrollment, access to services and other related matters;

c. help enrollees understand the fair hearing, grievance and appeal rights and processes within the health plan and at the state level, and assist them through the process if needed/requested; and

d. conduct trainings with MRT MCO and providers on community-based resources and supports that can be linked with covered plan benefits.

10.14. **Staffing.** The Independent Consumer Support Program must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs.

10.15. **Data Collection and Reporting.** The Independent Consumer Support Program shall track the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the state, but no less frequently than quarterly.

10.16. **Geographic expansion of MLTC and LTSS in MMMC.** In any geographic location where the state is mandating MLTC or LTSS in MMMC, the state must have the Independent Consumer Support Program in place at least 30 days prior to enrollment procedures for that geographic location.

10.17. **Required Monitoring Activities by the State and/or External Quality Review Organization (EQRO).** The state's EQR process for the MMMC and MLTC plans shall meet all the requirements of 42 CFR §438 Subpart E. In addition, the state, or its EQRO shall monitor and annually evaluate the MCO/PIHPs performance on specific new requirements under mandatory enrollment of individuals utilizing long term services and supports. The state shall provide an update of the processes used to monitor the following activities as well as the outcomes of the monitoring activities within the annual report in STC 14.7. The new requirements include, but are not limited to the following:

a. **MLTC Plan Eligibility Assessments.** To ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with LTSS meet the MLTC program eligibility requirements for plan enrollment. The state will also monitor assessments conducted by the plan where individuals are deemed ineligible for enrollment in an MLTC plan.

b. **Service Plans.** To ensure that MCOs are appropriately creating and implementing service plans based on the enrollee's identified needs.

c. **MCO credentialing and/or verification policies.** To ensure that LTSS services are provided by qualified providers.

10.18. **Access to Care, Network Adequacy and Coordination of Care Requirements for Long Term Services and Supports (LTSS)**. The state shall set specific access and coordination requirements for MCO. These standards should take into consideration individuals with special health care needs, out of network requirements if a provider is not available within the specific access standard, ensuring choice of provider with capacity to serve individuals, time/distance standards for providers who do not travel to the individual's home, and physical accessibility of covered services. The MLTC or MMMC plan is not permitted to set these standards.

10.19. **Demonstrating Network Adequacy**. Annually, each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate coverage of benefits as described for the anticipated number of enrollees in the service area.

a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:

i. the number and types of providers available to provide covered services to the demonstration population;

ii. the number of network providers accepting the new demonstration population; and

iii. the geographic location of providers and demonstration populations, as shown through GeoAccess, similar software or other appropriate methods.

b. The state must submit the documentation required in subparagraphs (i) – (iii) above to CMS with each annual report.

c. Enrollees and their representatives must be provided with reference documents to maintain information about available providers and services in their plans.

10.20. **Advisory Committee as required in 42 CFR §438**. The state must maintain for the duration of the demonstration a managed care advisory group comprised of individuals and interested parties appointed pursuant to state law by the Legislature and Governor. To the extent possible, the state will attempt to appoint individuals qualified to speak on behalf of seniors and persons with disabilities, including individuals with developmental disabilities, regarding the impact and effective implementation of the demonstration on individuals receiving LTSS.

10.21. **Health Services to Native Americans Populations**. The plan currently in place for patient management and coordination of services for Medicaid-eligible Native Americans developed in consultation with the Indian tribes and/or representatives from the Indian health programs located in participating counties shall continue in force for this extension period.

10.22. **Requirements for risk-based managed care plans.**

a. For risk-based plans, the state must submit the plan-generated reports detailed in 42 CFR 438.8(k) as well as any other documentation used to determine compliance with 42 CFR 438.8(k) to CMS at DMCPMLR@cms.hhs.gov.

i. For managed care plans that delegate risk to subcontractors, the state's review of compliance with 42 CFR 438.8(k) must consider MLR requirements related to such subcontractors; see https://www.medicaid.gov/federal-policy-guidance/downloads/cib051919.pdf. The state must submit its plan to operationalize STC 10.22.a.i through 10.22.a.v no later than six months after the demonstration approval. This plan must outline key deliverables and timelines to meet the requirements of STC 10.22.a. through 10.22.e.

b. Effective April 1, 2025, the state must require risk-based plans contracted with the state to impose reporting requirements equivalent to the information required in 42 CFR 438.8(k) on their subcontractor plans or entities.

c. No later than 1 year from date in 10.22.b, the state must require risk-based plans contracted with the state to impose remittance requirements equivalent to 42 CFR 438.8(j) on their subcontractor plans or entities.

d. STC 10.22.a., 10.22.b, and 10.22.c must apply for all of the following entities:

   i. Risk-based plans for which the state receives federal financial participation for associated expenditures;

   ii. Full and partially delegated plans;

   iii. Other subcontractors, as applicable, that assume delegated risk from either the primary managed care plan contracted with the state, or plans referenced in STC 10.22.d.ii; and

   iv. Other subcontractors, as applicable, that assume delegated risk from entities referenced in STC 10.22.d.iii.

e. The state must work with CMS to effectuate an audit of the MLR data for all complete rating periods (i.e., MLR reporting periods) in this 1115 demonstration package. Final audit results and reporting must be provided to CMS no later than two years after the expiration of the current demonstration period.

f. The state will update the managed care plan contract language to require managed care plans to provide HRSN services as described in STC 6.19. When HRSN services are included in risk-based capitation rates, as outlined in STC 6.15, HRSN services should be reported in the MLR reports as incurred claims. Managed care plans should not report HRSN services in the MLR until after the transition to include HRSN services in risk-based capitation rates. Managed care plans should report HRSN services paid on an at-risk basis, including care coordination, in the MLR.

   i. The state must develop an MLR monitoring and oversight process specific to HRSN services. This process must be submitted to CMS, for review and approval, no later than 18 months prior to the implementation of HRSN services in risk-based capitation rates. The state shall submit this process to CMS at DMCPMLR@cms.hhs.gov. This process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs and infrastructure will be identified and reported in the MLR as non-claims costs.

11. DESIGNATED STATE HEALTH PROGRAMS

11.1. The state may claim FFP for designated state health programs subject to the limits described below. This DSHP authority will allow the state to support DSHP-Funded Initiatives, as described in STC 11.3. This DSHP authority will be available from DY 25-DY 28.

a. The DSHP will have an established limit in the amount of $3,981,442,500 total computable expenditures, in aggregate, for DY 25-DY 28.

b. The state may claim FFP for up to the annual amounts outlined in Table 11, plus any unspent amounts from prior years. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period, and the state may claim the remaining amount in a subsequent demonstration year.

Table 11. Annual Limits in Total Computable Expenditures for DSHP

	DY 25	DY 26	DY 27	DY 28	Total
	01/09/2024 to 03/31/2024	04/01/2024 to 03/31/2025	04/01/2025 to 03/31/2026	04/01/2026 to 03/31/2027	
Total Computable Expenditures	$1.51B	$916M	$836M	$717M	$3.981B

c. The state must contribute $351,303,750 (state share) in original, non-freed up DSHP funds, for the remaining demonstration period ending on March 31, 2027, towards its initiatives described in STC 11.3. These funds may only derive from other allowable sources of non-federal share and must otherwise meet all applicable requirements of these STCs and the Medicaid statute and regulations.

d. The state attests, as a condition of receipt of FFP under the DSHP expenditure authority, that all non-federal share for the DSHP is allowable under all applicable statutory and regulatory requirements, including section 1903(w) of the Act and its implementing regulations. The state acknowledges that approval of the DSHP expenditure authority does not constitute approval of the underlying sources of non-federal share, which may be subject to CMS financial review.

e. As a post-approval protocol, the state shall submit an Approved DSHP List identifying the specific state programs for which FFP in expenditures can be claimed within 90 days of the demonstration approval date. The Approved DSHP List will be subject to CMS approval and will be limited to programs that are population- or public health-focused, aligned with the objectives of the Medicaid program with no likelihood that the program will frustrate or impede the primary objective of

Medicaid to provide coverage of services for low-income and vulnerable populations, and serve a community largely made up of low-income individuals. Only after CMS approves the list and ensures that none of the requested state programs fall within the exclusions listed in STC 11.2 can the state begin claiming FFP for DSHP expenditures. The Approved DSHP List will be appended to the STCs as Attachment N.

11.2. **Prohibited DSHP Expenditures.**

a. Allowable DSHP expenditures do not include any expenditures that are funded by federal grants or other federal sources (for example, American Rescue Plan Act funding, grants from the Health Resources and Services Administration, the Centers for Disease Control and Prevention, etc.) or that are included as part of any maintenance of effort or non-federal share expenditure requirements of any federal grant.

b. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid. To implement this limitation, 9.2 percent of total provider expenditures or claims through DSHP identified as described in STC 11.1 will be treated as expended for non-emergency care to individuals who do not meet citizenship or immigration status requirements, and thus not matchable. This adjustment is reflected in the total computable amounts of DSHP described in STC 11.1 and will be made prior to the state submitting claims via the CMS-64/ MBES system.

c. The following types of expenditures are not permissible DSHP expenditures: expenditures that are already eligible for federal Medicaid matching funds or other sources of federal funding, that are generally part of normal operating costs that would be included in provider payment rates, that are not likely to promote the objectives of Medicaid, or are otherwise prohibited by federal law. Exclusions that have historically fallen into these categories include, but are not limited to:

i. Bricks and mortar;

ii. Shelters, vaccines, and medications for animals;

iii. Coverage/services specifically for individuals who are not lawfully present or are undocumented;

iv. Revolving capital funds; and

v. Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

11.3. **DSHP-Funded Initiatives.**

a. **Definition.** DSHP-funded initiatives are Medicaid or CHIP section 1115 demonstration activities supported by DSHPs.

b. **Requirements.** Expenditures for DSHP-funded initiatives are limited to costs not otherwise matchable under the state plan. CMS will only approve those DSHP-funded initiatives that it determines to be consistent with the objectives of the Medicaid statute; specifically, to expand coverage (e.g., new eligibility groups or benefits), improve access to covered services including home- and community-based services and behavioral health services, improve quality by reducing health disparities, or increase the efficiency and quality of care. Funding for DSHP-funded initiatives will not be supplanting, nor merely supplementing existing services or programs. DSHP-funded initiatives must be new services or programs within the state. Funding for DSHP-funded initiatives specifically associated with infrastructure start-up costs for new initiatives is time limited to the current demonstration period and will not be renewed.

c. **Approved DSHP-Funded Initiatives.** The initiatives listed below are approved DSHP-funded initiatives for this demonstration. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.

i. HRSN Services

ii. HRSN Infrastructure

iii. Transportation, Cooking Supplies, and Brokerage Fees

iv. HERO

v. Workforce Initiatives

1. The state must not use freed up dollars from the state workforce DSHPs to fund the 1115 demonstration workforce initiatives.

11.4. **DSHP Claiming Protocol.** The state will develop and submit to CMS, within 150 calendar days of the approval of the demonstration, a DSHP Claiming Protocol subject to CMS approval with which the state will be required to comply in order to receive FFP in DSHP expenditures. State expenditures for the DSHP must be documented in accordance with the protocol. The state is not eligible to receive FFP until the protocol is approved by CMS, and upon approval, the state may only claim FFP for DSHP expenditures retrospectively to the effective date of the demonstration amendment that added this STC. Once approved by CMS, the protocol will be appended as Attachment O to these STCs, and thereafter may be changed or updated only with CMS approval. Changes and updates are to be applied prospectively. In order to claim FFP for DSHP expenditures, the state

will provide CMS a summary worksheet that identifies DSHP expenditures by program each quarter.

a. For all eligible DSHP expenditures, the state will maintain and make available to CMS upon request:

i. Certification or attestation of expenditures.

ii. Actual expenditure data from state financial information system or state client sub-system. The Claiming Protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in STC 11.2.

iii. The state will claim FFP for DSHP quarterly based on actual expenditures.

11.5. **DSHP Claiming Process.** Documentation of all DSHP expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs.

a. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. To the extent that the DSHPs receive federal funds from any other federal programs, such funds shall not be used as a source of non-federal share to support expenditures for DSHPs or DSHP-funded initiatives under this demonstration.

b. The administrative costs associated with DSHPs (that are not generally part of normal operating costs for service delivery) shall not be included in any way as demonstration and/or other Medicaid expenditures.

c. DSHP will be claimed at the general administrative matching rate of 50 percent.

d. Expenditures will be claimed in accordance with CMS-approved DSHP Claiming Protocol in Attachment O.

11.6. **Sustainability Plan.** The DSHP Sustainability Plan will describe the scope of DSHP-funded initiatives the state wants to maintain and the strategy to secure resources to maintain these initiatives beyond the current approval period. The state shall submit the DSHP Sustainability Plan to CMS no later than December 31, 2025, after the approval of this authority. Upon CMS approval, the plan will be appended as Attachment Q to these STCs. Any future modifications for the DSHP Sustainability Plan will require CMS approval.

12. WORKFORCE INITIATIVES

To support workforce recruitment and retention to promote the increased availability of certain health care practitioners who serve Medicaid and demonstration beneficiaries, the state shall implement two statewide workforce initiatives—the Student Loan Repayment for Qualified Providers and Career Pathways Training programs. Funding for these two workforce initiatives must not supplant state and federal funding or duplicate existing workforce loan repayment and professional training programs. New York will consult with the Health Resources and Services Administration (HRSA) as it works on these programs. The aim of these programs is to address shortages in qualified providers serving Medicaid members.

12.1. **Student Loan Repayment for Qualified Providers.** The state will make available the following student loan repayments:

a. **Psychiatrists, with a priority on child/adolescent psychiatrists -** Up to $300,000, per provider, who make a 4-year full-time commitment to maintaining a personal practice panel, or working at an organization with a panel, that includes at least 30 percent Medicaid and/or uninsured members.

b. **Primary care physicians and dentists** - Up to $100,000 per provider, who make a 4-year full-time commitment to maintaining a personal practice panel, or working at an organization with a panel, that includes at least 30 percent Medicaid and/or uninsured members.

c. **Nurse practitioners and pediatric clinical nurse specialists** - Up to $50,000, per provider, who make a 4-year full-time commitment to maintaining a personal practice panel, or working at an organization with a panel, that includes at least 30 percent Medicaid and/or uninsured members.

12.2. **Additional Terms and Operations of the Student Loan Repayment for Qualified Providers Program.** For the demonstration student loan repayment program, the following shall apply:

a. Loan repayments must be made directly only to the student loan servicer by either the state or a procured vendor. Funds will not be provided to individual practitioners. Payments will be made no less than annually.

i. If the state procures a vendor, the state will first pay the managing vendor, the funds, so that it can then in turn make payments to the loan servicers.

b. The state may have multiple rounds/cohorts of disbursements (i.e., awards to new individuals each year), so long as it does not extend beyond the applicable authorized level of funding for each program over the course of the demonstration or demonstration year, as applicable.

c. The state shall have a process for ensuring that providers are continuing to meet the qualifying service commitment no less than every 6 months before making loan repayment disbursements. If the service commitment is not met, except in extraordinary circumstances as determined by the state (for example, circumstances such as disability or death), the state shall not make the loan disbursement and the state shall recoup any student loan payments made on behalf of the program participant. In the case of recoupment, the state shall return the federal share of those payments to CMS. Suspension or revocation of a professional license does not constitute an extraordinary circumstance for purposes of not meeting the service commitment.

d. The state may only repay an amount up to the student loan amount owed by the provider. It may not pay an amount that exceeds an individual provider's student loan. Only the student loan for educational costs associated with the course of study that led to the highest degree earned as a prerequisite to obtaining the relevant clinical credential may qualify for reimbursement under one of the student loan repayment programs.

e. For the student loan repayment program, the state will define application criteria and eligibility, and select awardees through a competitive process that will allow the state to evaluate the applicants relative to the criteria established. The state may prioritize providers with cultural and linguistic competence that is likely to reflect and respond to the needs of the Medicaid population. The criteria must comply with federal civil rights law and not impermissibly discriminate based on race, ethnicity, national origin, or any other federally protected classes or characteristics.

12.3. **Career Pathways Training Program.** The Career Pathways Training (CPT) Program is designed to build up the allied health and other healthcare workforce by funding training and education that focus on career advancement and unemployed individuals in order to create a reliable healthcare workforce pipeline to address health workforce shortages throughout the state. The CPT program will be organized into no more than three regions to support statewide implementation and is divided into two career pipelines—Healthcare Career Advancement and New Careers in Healthcare.

a. **Healthcare Career Advancement Pipeline.** Individuals participating in the Healthcare Career Advancement Pipeline must be employed at a NY healthcare provider and accepted to participate in one of the CPT professional education programs described in STC 12.5. Participation will be conditioned on a 3-year commitment of service, in the new professional title, to healthcare providers enrolled in the Medicaid program that serve at least 30 percent Medicaid members and/or uninsured individuals.

b. **New Careers in Healthcare Pipeline.** Individuals participating in the New Careers in Healthcare Pipeline must be unemployed or not employed by a NY healthcare

provider and are accepted in one of the professional education programs described in STC 12.5. Participation will be conditioned on a 3-year commitment of service to healthcare providers enrolled in the Medicaid program that serve at least 30 percent Medicaid members and/or uninsured individuals.

c. The state shall develop a process to routinely monitor and verify that CPT program participants remain in compliance with the training curriculum and qualifying service commitment. If the training or service commitment is not met, except in extraordinary circumstances as determined by the state (for example, circumstances such as disability or death), the state shall recoup from the program participant all payments for tuition and associated fees made on behalf of the program participant and return the federal share of those payments to CMS within 1 year of the breach in the service commitment. Suspension or revocation of a professional license or certification does not constitute an extraordinary circumstance for purposes of not meeting the service commitment. CPT program participants must pass required professional state licensing or certification examinations and obtain requisite licensure or certification no later than 1 year of completing the degree programs listed in STC 12.5, except in extraordinary circumstances as determined by the state (for example, circumstances such as disability or death). Failure to obtain requisite licensure or certification will constitute a breach in the service commitment requirement.

d. The state may have multiple rounds/cohorts of disbursements (i.e., awards to new individuals each year), so long as it does not extend beyond the applicable authorized level of funding for each program over the course of the demonstration or demonstration year, as applicable. The cohorts will be structured to ensure that each program can be completed within the demonstration period.

12.4. **Workforce Investment Organizations.** The state will contract with Workforce Investment Organizations (WIOs) for the implementation, management, and oversight of the CPT Program in each region. The state will define WIO criteria and eligibility, and then select WIOs through a selection process that will allow the state to evaluate the applicants relative to the criteria established. The state must conduct oversight of the WIOs and use of funds through periodic WIO assessments of performance. The state has the authority to revoke designation of any WIO that no longer meets the state's qualifications, has failed to meet performance requirements, or does not comply with the conflict-of-interest requirements.

a. **Partnerships.** WIOs must establish the necessary partnerships to directly work with training and educational institutions, health systems, and CPT participants to coordinate training and education opportunities, provide meaningful support of the participants to assure successful completion of programs, and job placement to meet service commitments.

b. **Reporting to the state.** WIOs will be required to meet workforce training performance metrics identified by the state and CMS. WIOs must monitor and report CPT program participant compliance with service commitments no less than every quarter. The state may require WIOs to report necessary data to the Health Equity Regional Organization (HERO) responsible for data aggregation and statewide monitoring of WIOs.

c. **Conflicts of Interest.** The state must ensure that there are no conflicts of interest between WIOs (including WIO governance boards) and education institutions, healthcare entities and any other CPT program partner in which the WIO or the state will be responsible for selecting to provide CPT services. WIOs must be independent entities and must not be affiliated with any CPT program partners the WIOs will be paying for CPT related program costs (i.e., tuition, program fees, and backfill costs described in STC 12.6). WIOs with education institutions, healthcare entities and any other CPT program partners on their existing governance boards must establish a separate governance board for the oversight and management of CPT programs that excludes these partners to ensure no conflict of interest.

12.5. **CPT Professional Education Programs.** The CPT education and training offerings shall be limited to the course curriculums necessary to achieve the professional titles listed in STC 12.5(a)-(c). The state may identify additional healthcare occupations that may emerge as part of the state's initiative to address health related social needs for inclusion in CPT backed up by data/evidence supporting that there are workforce shortages similar to the categories below, but it must not alter the allowable funding in STC 12.7, and the state must receive prior CMS approval. The state must conduct oversight of WIOs and ensure CPT trainings are limited to the course curriculums listed in STC 12.5(a)-(c) and additional curriculums approved by CMS. The state will identify, screen, and select institutional entities that will provide the education and training to the CPT participants. The training programs must be certified or accredited by the state or organizations recognized by the state. WIOs must work with the institutional entities that meet the state's requirements.

a. Nursing Titles.

   i. Licensed Practical Nurse

   ii. Associate Registered Nurse

   iii. Registered Nurse to Bachelor of Science in Nursing

   iv. Nurse Practitioner

b. Professional Technical Titles

   i. Physician Assistant

ii. Licensed Mental Health Counselor

iii. Master of Social Work

iv. Credentialed Alcoholism and Substance Abuse Counselor

v. Certified Pharmacy Technician

vi. Certified Medical Assistant

vii. Respiratory Therapist

c. Frontline Public Health Workers

i. Community Health Worker

ii. Patient Care Manager/Coordinator

12.6. **Allowable Use of CPT Funds.** The state has authority for CPT expenditures within the limits specified in STC 12.7 for implementation of the CPT initiative. The CPT funds may only be used for the following:

a. Educational case management, WIO outreach to secure appropriate program partners, participant recruitment and academic support such as tutoring.

b. Program tuition and required program fees for course curriculums necessary to achieve the professional titles in STC 12.5.

c. Textbooks and supplies as required by the educational program curriculum.

d. Backfill for participants in the Health System Career Advancement Pipeline. To avoid reduced access to care when a participant is in training during participant working hours and recognizing the absence requires a temporary or covering worker to perform duties, the state may use funds to pay the health system employer to backfill the participant. Backfill costs must not exceed the following rates and no more than 2 days per week for participants in the following programs:

i. $175 per day for licensed practical nurse, associate registered nurse, credentialed alcohol and substance abuse counselor, certified pharmacy technician, respiratory therapist, certified medical assistant, community health worker, and patient care manager/coordinator.

ii. $259 per day for nurse practitioners, physician's assistants, Master of Social Work, and licensed mental health counselor.

iii. $300 per day for Registered Nurse to Bachelor of Science in Nursing.

e. Administrative expenses for operational and accounting expenses.

12.7. **Workforce Initiatives Funding.** The funding table below shows the maximum amount of funding for each workforce initiative (including 15 percent administrative costs) by demonstration year.

Table 12: Workforce Initiatives Funding

	DY 26	DY 27	DY 28	Total
	04/01/2024 to 03/31/2025	04/01/2025 to 03/31/2026	04/01/2026 to 03/31/2027	
Student Loan Repayment for Qualified Providers	$12.08M	$24.15M	$12.08M	$48.30M
Career Pathways Training	$175.77M	$310.48M	$159.50M	$645.75M
Total Computable	$187.85M	$334.63M	$171.58M	$694.05M

a. Subject to the total funding for each initiative in STC 12.7, the state may carry forward prior year student loan repayment and CPT unused expenditure authority from one year to the next. The state must notify CMS of any changes to annual amounts in the quarterly and annual monitoring reports.

b. All expenditures for the student loan repayment and CPT programs are only matchable as administrative expenditures. The state must ensure that the Workforce Initiatives Funding expenditures described in Section 12 are not factored into managed care capitation payments and that there is no duplication of funds.

c. The state must require that all CPT participants in programs listed in STC 12.5(a)-(b), make application to the Free Application for Federal Student Aid (FAFSA) and New York State's Tuition Assistance Program (TAP). The WIO may not make tuition payments on behalf of a program participant until both the FAFSA and New York's TAP applications have been submitted and a determination has been made on the amount of grant funding that will be received by the program participant.

d. Time limited expenditure authority is granted from April 1, 2027 until March 31, 2031, to allow the state to pay close-out administrative costs of operating the student loan repayment and CPT programs and monitor remaining service commitments. The state must adhere with federal timely filing requirements during this time-limited expenditure authority period. The expenditures will continue to be claimed on the CMS 64 on the specified waiver lines if the date where claims are made go beyond the demonstration period as part of this demonstration period. No payments for student loans, tuition and fees, books and required training supplies, case

management, and outreach may be made following the demonstration period's expiration (March 31, 2027).

e. The state must follow all federal statutes, regulations, and policies regarding individual eligibility requirements for Federal educational funding support.

12.8. **Workforce Initiatives Monitoring**. The state must report on the student loan repayment and CPT activities in quarterly and annual monitoring reports described in STC 15.16. The state must provide details regarding statewide and regional program recruitment, participation, completion, and status of service commitments. This must include performance rates, progress in reaching statewide targets (e.g., CPT participation by pipeline as described in STC 12.3), and the corrective actions taken if targets are not achieved. Additionally, the state must annually report statewide provider vacancy rates for the professional titles included in the CPT and the student loan repayment programs.

13. HEALTH EQUITY REGIONAL ORGANIZATION (HERO)

The HERO is a contracted statewide entity designed to develop regionally-focused approaches to reduce health disparities, advance health equity, and support the delivery of HRSN services. The HERO will coordinate data from various sources including, but not limited to, the SCNs, WIOs, and the Statewide Health Information Network for New York (SHIN-NY) to assess and address areas for improvement in health care quality and equity outcomes including the identification of disparities in health care delivery. This information will assist New York in developing and designing VBP goals to address HRSN and the most impactful health equity priorities. This authority does not presuppose approval of any particular VBP arrangement submitted by the state under any authority.

13.1. **HERO Activities –** The HERO will conduct the following activities:

a. Data aggregation: Data aggregation, analytics, and reporting on statewide demonstration implementation based on managed care organization (MCO)/ SCN/WIO/provider-submitted data, integrating different datasets across health and social services and systems to evaluate needs/ gaps in access to physical health, behavioral health, and HRSN services;

b. Regional needs assessment and planning: The HERO will conduct a regional needs assessment as part of its planning, perform data-driven annual regional planning, and draft and publish a statewide health equity plan (informed by regional health equity plans). The assessment must be made publicly available. The HERO will identify health care workforce-related needs and gaps. The state will include managed care contract provisions requiring plans to share data with the HERO;

c. Stakeholder engagement: Convene regional stakeholder engagement sessions.

d. Make recommendations to support advanced VBP arrangements and develop options for incorporating HRSN into VBP methodologies for the state to use by the end of the demonstration period; and

e. Program analysis, such as publishing initial health equity plans and health factor baseline data on Medicaid populations.

13.2. **Funding.** The allowable HERO funding is in the amount $125 million (total computable) for DY 25 through DY 28. Any amount of funding left may roll over from year to year. However, the total computable maximum amount available for HERO over the demonstration period is $125 million. The funding table below shows the maximum amount of funding for the HERO by demonstration year.

Table 13: HERO Funding

	DY 26	DY 27	DY 28	Total
	04/01/2024 to 03/31/2025	04/01/2025 to 03/31/2026	04/01/2026 to 03/31/2027	
HERO (Total Computable) Expenditure Authority	$50M	$40M	$35M	$125M

13.3. **State Assurances.** The state must provide assurances of the following:

a. None of the HERO funding may be used to supplant any existing state-only funding.

b. None of the HERO funding may be used to support or duplicate any services by the New York eHealth Collaborative (NYeC) or SHIN-NY.

c. The HERO must be independent from the state or other government entities.

d. The state must ensure that the HERO funding expenditures described in STC 13 are not factored into managed care capitation payments, and that there is no duplication of funds.

13.4. **Accountability.** The state must report on the activities of the HERO in the quarterly and annual monitoring reports. The state must include the recommendations and conclusions based on the HERO's data aggregation, stakeholder engagement, and future VBP arrangements for the delivery of HRSN services to be enacted in the extension request due March 31, 2026.

14. MONITORING AND REPORTING REQUIREMENTS

14.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) thirty (30) days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to the required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outline in these STCs, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

14.2. **Deferral of FFP from IMD claiming for Insufficient Progress Toward Milestones.** Up to $5 million in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in STC 8.2 and the required performance measures in the monitoring protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5 million will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

14.3. **Submission of Post-Approval Deliverables.** The state must submit all required analyses, reports, design documents, presentations, and other items specified in these STCs ("deliverables"). The state shall use the processes as stipulated by CMS and within the timeframes outlined within these STCs.

14.4. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

a. Ensure all section 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

b. Submit deliverables to the appropriate system as directed by CMS.

14.5. **SUD Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol for the SUD program authorized by this demonstration within 150 calendar days after approval of the demonstration amendment. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments, if any. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs as Attachment I. Progress on the performance measures identified in the SUD Monitoring Protocol must be reported via the Quarterly and Annual Monitoring Reports. Components of the SUD Monitoring Protocol must include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STCs 8.3 and 9.2, and information relevant to the state's HIT Plan described in STCs 8.3;

b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section 14 of the demonstration; and

c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and target will be benchmarked against performance in best practice settings.

14.6. **Monitoring Protocol for Other Policies.** The state must submit to CMS a Monitoring Protocol addressing components of the demonstration not covered by the SUD Monitoring Protocol within 150 calendar days after the approval of the demonstration amendment. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments, if any. Once approved, the Monitoring Protocol for Other Policies will be incorporated in the STCs as Attachment P. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, if applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as for specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., the performance metrics described in STC 14.7), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and demonstration component.

For the HRSN services authorized through this demonstration, the Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Disparities-Sensitive Measure Set, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. This set of measures represents a critical set of equity-focused metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g., the National Quality Forum (NQF) "disparities-

sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e., social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones, as provided in the Implementation Plan, for the HRSN infrastructure investments.

The state will also be expected to set up its HRSN service delivery system to allow screening of beneficiaries for identified needs, and to develop an appropriate closed-loop referral system or other feedback loop to ensure beneficiaries receive service referrals and provisions, and provide any applicable update on this process via the Monitoring Reports, in alignment with information provided in the Monitoring Protocol for Other Policies.

In addition, the state must describe in the Monitoring Protocol methods and timeline to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include, but are not limited to: (1) community resource referral platforms; (2) records of social services receipt from other agencies (such as SNAP or TANF benefits, or HUD assistance); (3) other data from social services organizations linked to beneficiaries (e.g., services rendered, resolution of identified need, as applicable); and (4) social needs screening results from electronic health records, health plans, or other partner agencies, as applicable. Across data sources, the state must make efforts and consult with relevant non-Medicaid social service agencies to collect data in ways that support analyses of data on beneficiary subgroups.

For the qualitative elements (e.g., operational updates as described in STC 14.7.a), CMS will provide the state with guidance on narrative and descriptive information, which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Monitoring Reports.

14.7. **Quarterly and Annual Monitoring Reports.** The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each DY. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/ Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates – Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports

must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration. The state must provide in monitoring reports operational progress and any challenges encountered and associated mitigation effects with moving non-emergency medical transportation (NEMT) and pharmacy to FFS.

b. Performance Metrics – Per applicable CMS guidance and technical assistance, the performance metrics will provide data to demonstrate how the state is progressing toward meeting the goals and milestones – including relative to their projected timelines – of the demonstration's program and policy implementation and infrastructure investments. Metrics in the state's Monitoring Reports must cover all key policies under this demonstration including, but not limited to, behavioral health, home and community-based services, and the provision of special services to certain populations (for example, through HARP or HIV SNPs), the Medicaid Hospital Global Budget Initiative, Workforce Initiatives, HRSN, HERO, and SUD components. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the effects of the demonstration on beneficiaries' outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, and grievances and appeals. The required monitoring and performance metrics must be included in the Monitoring Reports and must follow the framework provided by CMS to support federal tracking and analysis as applicable.

    i. The demonstration's metrics reporting must cover categories including, but not limited to enrollment and renewal, including enrollment duration, access to providers, utilization of services, and quality of care and health outcomes. The state must undertake robust reporting of quality of care and health outcomes metrics aligned with the demonstration's policies and objectives, to be reported for all demonstration populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified

disparities. To that end, CMS underscores the importance of the state's reporting of quality of care and health outcomes metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g., NQF "disparities-sensitive" measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e. social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Disparities-Sensitive Measure Set.

ii. For HRSN components, in addition to reporting on the metrics described above, the state must track beneficiary participation, screening, rescreening, receipt of referrals, recurring nutrition services, and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations, and the contracted providers of applicable services (e.g., managed care plans and their contracted HRSN providers). In alignment with STC 6.17, the state must additionally monitor and provide narrative updates on its progress in building and sustaining its partnership with existing housing and nutrition agencies, leverage their expertise and existing housing and nutrition resources instead of duplicating services. Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as SNAP and WIC) for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

iii. For the SUD component, the state's monitoring must cover metrics in alignment with the respective milestones as outlined in the State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMD #17–003).

iv. For the Workforce Initiatives, the state must report on the student loan repayment and CPT activities in the Monitoring Reports described in STC 14.5. The state must provide details regarding statewide and regional program recruitment, participation, completion, and status of service commitments. This must include performance rates, progress in reaching statewide targets (e.g., CPT participation by pipeline), and the corrective actions taken if targets are not achieved. Additionally, the state must annually report statewide provider vacancy rates for the professional titles included in the CPT and the student loan repayment programs. Narrative should also be included on the operations of the WIOs, including but not limited to WIO data reported to the

state, data reported to the HERO, workforce data reporting issues, and general summary information on WIO collaboration with stakeholders and the HERO.

v. For the HERO component, the state must provide narrative and data around the HERO's five main operations:

   a) Data aggregation. Each Monitoring Report should include summary narrative on what data the HERO attained, what is analyzed, and its main findings. Narrative should also be included on which organizations, if any, are having data reporting issues and what steps are being taken to alleviate the problem.
   b) Regional Needs Assessment and Planning. Each Monitoring Report should include narrative on HERO activities in regard to regional needs assessments, health equity plans, and workforce gaps. The current status of data sharing arrangements with managed care organizations should also be included.
   c) Stakeholder engagement. Each Monitoring Report should include summaries of any conducted regional stakeholder engagement sessions, which should include attendee information and public comment. If, at any point, stakeholders raise significant concerns with the HERO's performance, Monitoring Reports should include summary of the issue and steps toward resolution.
   d) Future VBP arrangements. Each Monitoring Report should include status of development of future VBP arrangements. At the initial phase of implementation of the HERO, Monitoring Reports should contain initial stakeholder/state ideas for arrangements and process on how future VBP arrangements will be developed (e.g., what criteria, etc.). For the second year of the HERO's activities, the Monitoring Reports should include preliminary data and takeaways, as well as an initial skeleton proposal of a future VBP arrangement. Final future VBP arrangements should be included in subsequent Monitoring Reports as well as evaluation reports.
   e) Program Analysis. Monitoring Reports should include an overview of any work done on health equity plans and health factor baseline data.

vi. For the Medicaid Hospital Global Budget Initiative, Monitoring Reports should include the required data and reports outlined in STC 9.3-9.7, as well as data on relevant quality measures, including their progress toward pre-stipulated targets for the program. By the end of the first year of the initiative's implementation, the state must submit data that confirms each hospital's eligibility in accordance with STC 9.1.a, 9.1.b, and 9.1.c. Reports should include payor mix calculations, operating margin calculations, data on state-only subsidies received, as well as data on hospital uncompensated care costs, including bad debt and charity care. Each Annual Monitoring Report

should also include narrative on which hospitals are intending to adopt the AHEAD CMMI model.

vii. In order to ensure a link between DSHP-funded initiatives and improvements in health equity and beneficiary health outcomes, CMS and the state will coordinate to use the critical set of disparities-sensitive metrics described above, with applicable demographic stratification. In addition, the state must demonstrate through its annual monitoring reporting to CMS improvements in Medicaid fee-for-service base provider reimbursement rates and reimbursement rates for providers enrolled in managed care to the extent required by STC 15.

viii. As applicable, if the state, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the state must use monitoring metrics that track the number and characteristics of contracted or participating organizations in specific demonstration programs and corresponding payment-related metrics; these metrics are specifically relevant for the state's HRSN initiatives and the DSHP-funded initiatives.

c. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR § 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Quarterly and Annual Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

d. Evaluation Activities and Interim Findings – Per 42 CFR § 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

14.8. **SUD Mid-Point Assessment.** The state must contract with an independent entity to conduct an independent Mid-Point Assessment by September 30, 2026. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning, and conduct of the Mid-Point Assessment, the state must require that the independent assessor consult with key

stakeholders including, but not limited to representatives of MCOs, health care providers (including SUD treatment providers), beneficiaries, community groups, and other key partners.

The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations. The state must provide a copy of the report to CMS no later than 60 calendar days after September 30, 2026, and the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

14.9. For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS proposed modifications to the SUD Implementation Plan and SUD Monitoring Protocol, for ameliorating these risks. Modifications to any of these plans or protocols are subject to CMS approval.

14.10. Elements of the Mid-Point Assessment must include at least:

a. An examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plan, and toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

c. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets identified by the independent assessor as at medium to high risk of not being met, recommendations for adjustments in the state's SUD Plan or to other pertinent factors that the state can influence that will support improvement; and

e. An assessment of whether the state is on track to meet the budget neutrality requirements in these STCs.

14.11. **Compliance with Managed Care, Network Adequacy, Quality Strategy and EQR Reporting Requirements**. The state must comply with all managed care reporting regulations at 42 CFR Part 438 et. seq., except as expressly identified as not applicable in the expenditure authorities incorporated into these STCs.

14.12. **Reporting Requirements Related to Individuals using Long Term Services and Supports.** In each quarterly report required by STC 14.7 the state shall report:

a. Any critical incidents reported within the quarter and the resulting investigations as appropriate.

b. The number and types of grievance and appeals for this population filed and/or resolved within the reporting quarter for this population.

c. The total number of assessments for enrollment performed by the plans, with the number of individuals who did not qualify to enroll in an MLTC plan.

d. The number of individuals referred to an MLTC plan that received an assessment within 30 days.

e. The number of people who were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials.

f. Rebalancing efforts performed by the MLTC and MMMC plans once the benefit is added. Rebalancing reporting should include, but is not limited to, the total number of individuals transitioning in and out of a nursing facility within the quarter.

g. The total number of complaints, grievances and appeals by type of issue with a listing of the top 5 reasons for the event.

14.13. **Corrective Action Plan Related to Demonstration Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial, sustained directional change, inconsistent with state targets and goals, as applicable, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

14.14. **Close-Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. The state will present to and participate in a discussion with CMS on the Close-Out Report.

c. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

d. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

e. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 14.1.

14.15. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

14.16. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within 6 months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

15. GENERAL FINANCIAL REQUIREMENTS

15.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for

allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.[8]

15.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

15.3. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in section 16:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration approval period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

15.4. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies federal funds provided under this section 1115 demonstration must not be

[8] For a description of CMS's current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Act, see State Medicaid Director Letter #18-009.

used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

15.5. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c). for purposes of certifying public expenditures.

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

15.6. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, PIHP, and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.8, 438.60 and 438.74.

15.7. **Requirements for health care related taxes and provider donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All health care-related taxes as defined by Section 1903(w)(3)(A) of the Social

b. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

c. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

d. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

e. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

f. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

15.8. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 14.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

15.9. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 16:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

15.10. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

15.11. **Medicaid Expenditure Groups (MEGs).** MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 14: Main MEG Chart

MEG	To Which BN Test Does This Apply?	Without waiver (WOW) Per Capita	WOW Aggregate	WW	Brief Description
TANF Child	Main	X		X	Demonstration Population 1 (see Table 1)
TANF Adult	Main	X		X	Demonstration Population 2 (see Table 1)
SSI 0 through-64	Main	X		X	Demonstration Population 3 (see Table 1)
SSI 65 and above	Main	X		X	Demonstration Population 4 (see Table 1)

Non-Duals 18-64	Main	X		X	Demonstration Population 5 (see Table 1)
Non-Duals 65+	Main	X		X	Demonstration Population 6 (see Table 1)
MLTC Adults 18 -64 Duals	Main	X		X	Demonstration Population 7 (see Table 1)
MLTC Age 65+ Duals	Main	X		X	Demonstration Population 8 (see Table 1)
HCBS Expansion	Main			X	Demonstration Population 9: Individuals who are not otherwise eligible, are receiving HCBS, and who are determined to be medically needy based on New York's medically needy income level, after application of community spouse and spousal impoverishment eligibility and post-eligibility rules consistent with section 1924 of the Act.
Institution to Community	Main			X	Demonstration Population 10: Individuals moved from institutional nursing facility settings to community settings for long term services and supports who would not otherwise be eligible based on income, but whose income does not exceed the income standard described in STC 4.4(c), and who receive services through the managed long-term care program under the demonstration

BH HCBS	Main			X	Demonstration Services 8: Expenditures made for BH HCBS for individuals enrolled in HARPs and HIV SNPs. Note: Expenditures under this EG will be claimed in the manner necessary to ensure the correct claiming of FMAP for all populations (e.g., BH HCBS for the adult expansion groups will be claimed at the FMAP rate at STC 15.15).
Demonstration Only Services in MMMC	Main			X	Demonstration Services 9: Expenditures made for provision of residential addiction services, crisis intervention and licensed behavioral health practitioner services to MMMC enrollees only and are not provided under the state plan.
New Adult Group	Hypo1	X		X	Demonstration Population 11 • CMS 64.9 VIII Waiv – New Adult Group Newly Eligible • CMS 64.9VIII Waiv – New Adult Group Not Newly Childless Adults • CMS 64.9VIII Waiv – New Adult Group Not Newly Children 19-20 • CMS 64.9VIII Waiv – New Adult Group Not Newly Parents & Caretakers
Fo1 Children	Hypo2	X		X	Demonstration Population 12

ADM	None				Demonstration related administrative costs, as discussed in STC 15.12(d)
Transportation	Main			X	All expenditures for Transportation provided under HRSN
Cooking Supplies	Main			X	All expenditures for cooking supplies provided under HRSN outside of one-time transitions.
Brokerage Fees	Main			X	All expenditures for brokerage fees provided under HRSN
HRSN Services	Capped Hypo		X	X	All expenditures for certain HRSN initiatives.
HRSN Infrastructure	Capped Hypo		X	X	All infrastructure expenditures for certain HRSN initiatives.
SUD IMD	Hypo 3	X		X	All expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Section 8.
Medicaid Hospital Global Budget and Equity Initiative	Main			X	All expenditures for the Medicaid Hospital Global Budget and Equity Initiative described in Section 9.
DSHP	Main			X	All expenditures for DSHP described in Section 11.
Student Loan Repayment	Main			X	All expenditures for the Student Loan Repayment for Qualified Providers program described in Section 12.

CPT	Main			X	All expenditures for the Career Pathways Training program described in Section 12.
HERO	Main			X	All expenditures for the HERO described in Section 13.

15.12. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00114/2). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section 16, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in STC 14.7, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 15: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
TANF Child	Expenditures for medical assistance MMMC benefits for TANF Child	Exclude individuals described in Table 2. Exclude BH HCBS and Demonstration Only Services in MMMC.	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	10/01/97	03/31/27
TANF Adult	Expenditures for medical assistance MMMC benefits for TANF Adult	Exclude individuals described in Table 2. Exclude BH HCBS and Demonstration Only Services in MMMC.	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	10/01/97	03/31/27
SSI 0 through-64	Expenditures for medical assistance MMMC benefits for SSI 0 through-64	Exclude individuals described in Table 2. Exclude BH HCBS and Demonstration Only Services in MMMC.	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	10/01/97	03/31/27
SSI 65 and above	Expenditures for medical assistance MMMC benefits for SSI 65 and above	Exclude individuals described in Table 2. Exclude BH HCBS and Demonstration Only Services in MMMC.	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	10/01/97	03/31/27
Non-Duals 18-64	Expenditures for medical assistance	Exclude individuals	Follow CMS-64.9 Base	Date of service	MAP	Y	08/31/12	03/31/27

	MLTC benefits for Non-Duals 18-64	described in Table 4.	Category of Service Definitions					
Non-Duals 65+	Expenditures for medical assistance MLTC benefits for Non-Duals 65+	Exclude individuals described in Table 4.	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	08/31/12	03/31/27
MLTC Adults 18 -64 Duals	Expenditures for medical assistance MLTC benefits for MLTC Adults 18 -64 Duals	Exclude individuals described in Table 4.	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	08/31/12	03/31/27
MLTC Age 65+ Duals	Expenditures for medical assistance MLTC benefits for MLTC Age 65+ Duals	Exclude individuals described in Table 4.	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	08/31/12	03/31/27
HCBS Expansion	Home and community-based services expenditures for Demonstration Population 9	None	Line 19A	Date of service	MAP	N	04/08/10	03/31/27
Institution to Community	All medical assistance expenditures for Institution to Community	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	N	08/31/12	03/31/27
BH HCBS	All medical assistance expenditures for BH HCBS	None	Line 19A	Date of service	MAP	N	07/29/15	03/31/25
Demonstration Only Services in MMMC	All medical assistance expenditures and Demonstration Only Services in MMMC	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	N	07/29/15	03/31/27

New Adult Group	Expenditures for medical assistance for New Adult Group	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	01/01/14	03/31/27
Fo1 Children	All medical assistance expenditures for Fo1 Children	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	04/01/19	03/31/27
ADM	Demonstration related administrative costs, as discussed in STC 1616.10(e)	None	Follow CMS-64.10 Base Category of Service Definitions	Date of payment	ADM	N	10/01/97	03/31/27
HRSN Services	Reimburse the state for expenditures on HRSN services	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	N	01/09/24	03/31/27
HRSN Infrastructure	Reimburse the state for expenditures on HRSN infrastructure	None	Follow CMS-64.10 Base Category of Service Definitions	Date of service	ADM	N	01/09/24	03/31/27
Transportation	Report all expenditure for the transportation benefit under HRSN	None	Follow CMS-64.10 Base Category of Service Definitions	Date of service	ADM	N	01/09/24	03/31/27
Cooking Supplies	Report all expenditure for the cooking supplies benefit under HRSN	None	Follow CMS-64.10 Base Category of Service Definitions	Date of service	ADM	N	01/09/24	03/31/27
Brokerage Fees	Report all expenditures for the brokerage fee benefit under HRSN	None	Follow CMS-64.10 Base Category of	Date of service	ADM	N	01/09/24	03/31/27

			Service Definitions					
DSHP	Report all DSHP expenditures.	None	Follow CMS-64.10 Base Category of Service Definitions	Date of service	ADM	N	01/09/24	3/31/27
HERO	Report all HERO expenditures	None	Follow CMS-64.10 Base Category of Service Definitions	Date of service	ADM	N	01/09/24	3/31/27
Medicaid Hospital Global Budget Initiative	Report all Medicaid Hospital Global Budget Initiative expenditures	None	Follow CMS-64.10 Base Category of Service Definitions	Date of service	ADM	N	01/09/24	3/31/27
SUD IMD TANF Children 1-20	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Section 8.	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	01/09/24	03/31/27
SUD IMD TANF Adults 21-64	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Section 8.	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	01/09/24	03/31/27

SUD IMD SSI 0-64	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Section 8.	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	01/09/24	03/31/27
SUD IMD New Adult Group	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Section 8.	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	01/09/24	03/31/27
SUD IMD FFS	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Section 8.	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	01/09/24	03/31/27
Student Loan Repayment	Report all expenditures for the student loan repayment program.	None	Follow CMS-64.10 Base Category of Service Definitions	Date of payment	ADM	N	01/09/24	03/31/27
CPT	Report all expenditures for	None	Follow CMS-64.10	Date of payment	ADM	N	01/09/24	03/31/27

	the Career Pathways Training initiative.		Base Category of Service Definitions					

15.13. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 16: Demonstration Years

Demonstration Year 24	April 1, 2022 to March 31, 2023	12 months
Demonstration Year 25	April 1, 2023 to March 31, 2024	12 months
Demonstration Year 26	April 1, 2024 to March 31, 2025	12 months
Demonstration Year 27	April 1, 2025 to March 31, 2026	12 months
Demonstration Year 28	April 1, 2026 to March 31, 2027	12 months

15.14. **Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group.** Because not all "newly eligible" individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) would be eligible for the entire continuous eligibility period if the state conducted redeterminations, CMS has determined that 97.4 percent of expenditures for individuals defined in 42 CFR 433.204(a)(1) will be matched at the "newly eligible" FMAP rate as defined in 42 CFR 433.10(c)(6) and 2.6 percent will be matched at the state's regular title XIX FMAP rate. Should state data indicate that there is an estimate more accurate than 2.6 percent by which to adjust claiming for individuals defined in 42 CFR 433.204(a)(1), CMS will work with the state to update this percentage to the more accurate figure, as supported by the state's proposed methodology and data.

15.15. **State Reporting for the Continuous Eligibility FMAP Adjustment.** 97.4 percent of expenditures for "newly eligible" individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) shall be claimed at the "newly eligible" FMAP rate as defined in 42 CFR 433.10(c)(6), unless otherwise adjusted as described in STC 15.14 above. The state must make adjustments on the applicable CMS-64 waiver forms to claim the remaining 2.6 percent or other applicable percentage of expenditures for individuals defined in 42 CFR 433.204(a)(1) at the state's regular Title XIX FMAP rate.

15.16. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using

the Budget Neutrality Monitoring Tool provided through the PMDA system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in section 16. CMS will provide technical assistance, upon request.[9]

15.17. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

15.18. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the

[9] 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

15.19. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 15.19.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following:

mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

16. MONITORING BUDGET NEUTRALITY

16.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, one or more Hypothetical Budget Neutrality Tests, and a Capped Hypothetical Budget Neutrality Test, if applicable, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

16.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 17, Master MEG Chart and Table 13, MEG Detail

for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

16.3. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver per member per month (PMPM) cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

16.4. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 17: Main Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR SFY 2020	TREND	DY 24	DY 25	DY 26	DY 27	DY 28
TANF Child	PC	Both	$274.63	2.8%	$280.79	$307.49	$316.30	$325.36	$334.68
TANF Adult	PC	Both	$724.05	5.3%	$645.25	$813.50	$837.54	$862.29	$887.77
SSI 0 through-64	PC	Both	$2,126.11	4.3%	$1,482.78	$2,623.27	$2,764.76	$2,913.88	$3,071.04
SSI 65 and above	PC	Both	$1,973.08	3.9%	$1,258.60	$2,434.45	$2,565.75	$2,704.14	$2,849.99
Non-Duals 18-64	PC	Both	$6,763.46	4.3%	$7,099.76	$6,990.06	$7,047.89	$7,106.20	$7,164.99
Non-Duals 65+	PC	Both	$6,574.94	3.9%	$4,683.43	$6,795.23	$6,85145	$6,908.13	$6,965.28
MLTC Adults 18 -64 Duals	PC	Both	$3,643.74	4.3%	$4,399.60	$3,765.82	$3,796.97	$3,828.38	$3,860.05
MLTC Age 65+ Duals	PC	Both	$5,073.30	3.9%	$4,655.45	$5,243.28	$5,286.26	$5,330.40	$5,374.50
HCBS Expansion	Agg	WW only	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Institution to Community	Agg	WW only	n/a	n/a	n/a	n/a	n/a	n/a	n/a
BH HCBS	Agg	WW only	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Demonstration Only Services in MMMC	Agg	WW only	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Transportation	Agg	WW Only	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Cooking Supplies	Agg	WW Only	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Brokerage Fees	Agg	WW Only	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Student Loan Repayment	Agg	WW only	n/a	n/a	n/a	n/a	n/a	n/a	n/a
CPT	Agg	WW only	n/a	n/a	n/a	n/a	n/a	n/a	n/a
SUD TANF 1-20	PC	Hypo	$298.35	4.9%	n/a	$312.97	$328.31	$344.40	$361.28
SUD TANF 21-64	PC	Hypo	$845.39	4.8%	n/a	$885.97	$928.50	$973.07	$1,019.78
SUD SSI 0-64	PC	Hypo	$2,412.34	5.0%	n/a	$2,532.96	$2,659.61	$2,792.59	$2,932.22
SUD New Adult	PC	Hypo	$739.66	4.6%	n/a	$773.68	$809.27	$846.50	$885.44
SUD	PC	Hypo	$7,449.29	4.8%	n/a	$7,806.86	$8,181.59	$8,574.31	$8,985.88
HERO	Agg	WW only	n/a	n/a	n/a	n/a	n/a	n/a	n/a
DSHP	Agg	WW only	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Medicaid Hospital	Agg	WW only	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Global Budget Initiative									

***PC = Per Capita, Agg = Aggregate**

16.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

a. **Hypothetical Budget Neutrality Test 1: New Adult Group.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 18: New Adult Group

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR SFY 2020	TREND	DY 24	DY 25	DY 26	DY 27	DY 28
New Adult Group	PC	Both	$624.56	5.8%	$739.66	$782.56	$827.95	$875.97	$926.78

b. **Hypothetical Budget Neutrality Test 2: Fo1 Children.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 19: Fo1 Children

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR SFY 2020	TREND	DY 24	DY 25	DY 26	DY 27	DY 28
Fo1 Children	PC	Both	$4,764.24	0%	$4,764.24	$4,764.24	$4,764.24	$4,764.24	$4,764.24

c. **Hypothetical Budget Neutrality Test 3: SUD.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 20: SUD IMD Expenditures

MEG	PC or Agg *	WOW Only, WW Only, or Both	BASE YEAR SFY 2023	TREND	DY 24	DY 25	DY 26	DY 27	DY 28
SUD IMD TANF Children 1-20	PC	Both	$845.39	4.8%	N/A	$312.97	$328.31	$344.40	$361.28
SUD IMD TANF Adults 21-64	PC	Both	$845.39	4.8%	N/A	$885.97	$928.50	$973.07	$1,019.78
SUD IMD SSI 0-64	PC	Both	$2,412,34	5.0%	N/A	$2,532.96	$2,659.61	$2,792.59	$2,932.22
SUD IMD New Adult Group	PC	Both	$739.66	4.6%	N/A	$773.68	$809.27	$846.50	$885.44
SUD IMD FFS	PC	Both	$7,449.29	4.8%	N/A	$7,806.86	$8,181.59	$8,574.31	$8,985.88

16.6. **Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in section 6), CMS considers these expenditures to be "capped hypothetical" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the Capped Hypothetical Budget Neutrality Test's expenditure limit for a given

demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.

16.7. **Capped Hypothetical Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 21: Capped Hypothetical Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or Both	DY 24	DY 25	DY 26	DY 27	DY 28
HRSN Services	Agg	Both	n/a	n/a	$766,098,515	$1,105,504,871	$2,190,343,076
HRSN Infrastructure	Agg	Both	n/a	$20,000,000	$275,000,000	$225,000,000	$79,990,000

16.8. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Main or Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

16.9. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the table below as a guide for determining when corrective action is required.

Table 22: Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0.0 percent

17. EVALUATION OF THE DEMONSTRATION

17.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation—including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable—in a federal learning collaborative aimed at cross state technical assistance, and identification of lessons learned and best practices for demonstration measurement,

data development, implementation, monitoring, and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in Section 14.1**.**

17.2. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

17.3. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval date of the demonstration. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The draft Evaluation Design must be drafted in accordance with Attachment G (Evaluation Design) of these STCs, and any applicable evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic)—as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STC 18.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment components. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

17.4. **Evaluation Budget.** A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation, such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

17.5. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Monitoring Reports.

17.6. **Evaluation Questions and Hypotheses.** Consistent with Attachments E and F (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP; Consumer Assessment of Health Care Providers and Systems (CAHPS); the Behavioral Risk Factor Surveillance System (BRFSS) survey; and/or measures endorsed by NQF.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to the HRSN demonstration components, and housing related support services. In addition,

the state is also strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key and novel demonstration initiatives happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Hypotheses must cover all policies and goals of the demonstration and should be crafted to not only evaluate whether overall demonstration goals were achieved but also the extent to which each component contributed to outcomes. Where demonstration components offer tailored service to specific populations, evaluation hypotheses must include an assessment of whether these programs improved quality of care outcomes and access to health care for the targeted population while also promoting the desired administrative and fiscal efficiencies. The evaluation questions and hypotheses should address the impacts of the following demonstration initiatives, including but not be limited to:

a. Evaluation hypotheses for the HRSN demonstration components must focus on areas such as assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on prevalence and severity of beneficiaries' HRSNs and the provision of beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include analysis of how the initiatives affect utilization of preventive and routine care; utilization of and costs associated with potentially avoidable, high-acuity health care; utilization of hospital and institutional care; and beneficiary physical and mental health outcomes.

   In addition, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the state must provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys).

   Hypotheses must be designed to help understand, in particular, the impact of housing supports, case management, nutritional services, and transportation support toward accessing covered HRSN services and case management activities on beneficiary health outcomes and experience. In alignment with the demonstration's objectives

to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level. As specified in STC 6.7.g., the state must also include research questions and hypotheses focused on how renewals of recurring nutrition services affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing supports and nutrition services change over time in concert with new Medicaid funding toward those services. In addition, considering how the demonstration's HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. Evaluation of the HRSN initiative is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

b. Hypotheses for the SUD program must include an assessment of the objectives of the SUD component of this section 1115 demonstration. Examples include, but are not limited to, initiative and engagement; compliance with treatment, utilization of health services (e.g., emergency department and inpatient hospital settings), and a reduction in key outcomes, such as deaths due to overdose.

c. The state's evaluation efforts must develop robust hypotheses and research questions to assess the effectiveness of the state's DSHP-funded initiatives in meeting the desired goals of such programs in advancing and complementing its broader HRSN and other applicable initiatives for its Medicaid beneficiaries and other low-income populations. The analysis must be designed to help demonstrate how these programs support, for example, expanding coverage, improving access, reducing health disparities, and/or enhancing home-and-community-based services or services to address HRSN or behavioral health.

d. For the Workforce Initiatives, the state must develop hypotheses and research questions to evaluate the effects of the initiatives on beneficiary access to care, as compared to what may be achieved through direct interventions such as rate increases. The state should also evaluate how close estimated costs and positions awarded of each CPT were to actual costs and awards, how effective backfill costs

were at retaining work levels while the backfilled individual left for CPT, improvements in overall staffing levels, the quality of the WIO workforce training performance measures, and long-term effects of the workforce programs on retention. The Evaluation Design must outline hypotheses and research questions to assess whether these initiatives sustainably reduce workforce shortages and increase provider retention, especially in the concentration areas such as primary care, behavioral health, and family practice. Because these initiatives may affect a small number of providers, the state is strongly encouraged to use a mixed-methods approach that would incorporate qualitative data sources, including interviews and/or focus groups with participating providers, and beneficiary experience surveys. Any qualitative component should also include evaluation of WIO performance.

e. The state's evaluation efforts must also include developing hypotheses and research questions to assess the effectiveness of the Medicaid Hospital Global Budget Initiative in ensuring provision of consistent high-quality care to all beneficiaries, as well as progress toward adopting global payment methodologies. Evaluation is expected to assess progress toward the quality and completeness of reporting on stratified data elements. Quantitative evaluation should focus on the effects of the Medicaid Hospital Global Budget Initiative payments toward improving hospital operating margins, as well as analyses of hospital financial health, identifying any hospitals that continued to have negative margin after payments, or had greater than 5 percent margin after payments, and potential mitigation strategies. Qualitative interviews should be conducted with hospitals and stakeholders to inform understanding of what led to hospital financial distress, how the Medicaid Hospital Global Budget Initiative payments have helped, and what other steps could be taken to improve long-term financial viability of hospitals accepting a large uninsured/Medicaid payor mix.

f. The state is expected to evaluate the effectiveness of the HERO in conducting the five main activities: data aggregation, regional needs assessment, stakeholder, engagement, designing value-based payment, and program analysis. The state is strongly encouraged to add a qualitative component in which interviews with entities interacting with the HERO are conducted to inform on its effectiveness.

g. As part of its evaluation efforts, the state must conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. The state must analyze the budgetary effects of the HRSN services, and the overall medical assistance service expenditures and uncompensated care and associated costs for populations eligible for continuous eligibility, including in comparison to populations not eligible for such policies. In addition, the state must use findings from hypothesis tests aligned with other

demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

17.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension of the demonstration, the Interim Evaluation Report should be posted to the state's Medicaid website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted. If the state is not requesting an extension for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. The state must submit revised Interim Evaluation Reports 60 calendar days after receiving CMS comments on the draft report, if any.

d. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

e. The Interim Evaluation Report must comply with Attachment F (Preparing the Interim and Summative Evaluation Reports) of these STCs.

17.8. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration's approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment F (Preparing the Interim and Summative Evaluation Reports) of these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

c. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

a. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

17.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

17.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation reports, and/or the Summative Evaluation Report. Presentations may be conducted remotely.

17.11. **Public Access**. The state shall post the final documents (e.g., Implementation Plans, Monitoring Protocols, Monitoring Reports, Mid-Point Assessment, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

17.12. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration, over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

18. SCHEDULE OF DELIVERABLES FOR DEMONSTRATION

In general, all deliverables are subject to revisions upon CMS review and feedback. Revised

deliverables are generally due to CMS 60 days after receipt of CMS feedback.

Table 23: Schedule of Demonstration Deliverables

STC Section	Demonstration Deliverable	Due Date	Frequency
6	Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services.	Due to CMS 90 calendar days after the approval of the amendment.	One-time
6	HRSN Implementation Plan	Within 9 months of the amendment's approval	One-time
9	Medicaid Hospital Global Budget Initiative Implementation Protocol	By April 1, 2025	One-time
8	SUD Implementation Plan	Within 90 days of the amendment's approval	One-time
14	SUD Monitoring Protocol	Due to CMS 150 days after the amendment approval	One-time
14	Monitoring Protocol for Other Policies	Due to CMS 150 days after the amendment approval	One-time
14	SUD Mid-Point Assessments	No later than 60 calendar days after September 31, 2026	One-time
17	Evaluation Design	Due to CMS 180 days after approval of the demonstration amendment	One-time
17	Interim Evaluation Reports	One year prior to current expiration date, March 31, 2026	One-time

STC Section	Demonstration Deliverable	Due Date	Frequency
17	Summative Evaluation Report	Due to CMS 18 months after the end of the demonstration approval period	One-time
14	Close-Out Report (applicable if demonstration or demonstration component expires)	Due to CMS 120 calendar days after the expiration of the demonstration	One-time
11	Approved DSHP List	Within 90 calendar days of the amendment's approval	One-time
11	DSHP Claiming Protocol	Within 150 calendar days of the amendment's approval	One-time
11	DSHP Sustainability Plan	By December 1, 2025	One-time
7	Provider Rate Increase Attestation Table and Supporting Information	Within 90 days of the amendment's approval	One-time
7	Annual Attestation of Provider Rate Increase	Annually, as part of demonstration annual report.	Ongoing
14	Quarterly Monitoring Report	Due to CMS 60 days after the end of each demonstration quarter	Ongoing
14	Quarterly Budget Neutrality Report	Due to CMS 60 days after the end of each demonstration quarter	Ongoing
14	Annual Monitoring Report	Due to CMS 90 days after the end of each demonstration year	Ongoing

ATTACHMENT A
Home and Community-Based Services Expansion Program Benefits

Assistive Technology (including personal emergency response system)
Community Integration Counseling and Services

Community Transition Services
Congregate/Home Delivered Meals
Environmental Modifications
Home and Community Support Services
Home Maintenance
Home Visits by Medical Personnel
Independent Living Skills Training
Intensive Behavioral Programs
Medical Social Services
Moving Assistance
Nutritional Counseling/Education
Peer Mentoring
Positive Behavioral Interventions
Respiratory Therapy
Respite Care/Services
Service Coordination
Social Day Care (including transportation)
Structured Day Program
Substance Abuse Programs
Transportation
Wellness Counseling Services

All HCBS Expansion program participants may not receive all benefits listed above. An individual participant's access to the benefits below may vary based on the individual's similarity to an individual determined eligible for and enrolled in the NHTD or TBI 1915(c) waiver program.

Home and community-based services (HCBS) must be provided in a setting that includes the following qualities:

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not

receiving Medicaid HCBS.

- ☐ The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- ☐ Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- ☐ Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- ☐ Facilitates individual choice regarding services and supports, and who provides them.
- ☐ In a provider-owned or controlled residential setting, in addition to the qualities specified above, the following additional conditions must be met:

1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

2. Each individual has privacy in their sleeping or living unit:

- ☐ Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
- ☐ Individuals sharing units have a choice of roommates in that setting.
- ☐ Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

3. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

4. Individuals are able to have visitors of their choosing at any time.

5. The setting is physically accessible to the individual.

6. Any modification of the additional conditions specified in items 1 through 4

above, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person- centered service plan.
- Document less intrusive methods of meeting the need that have been tried but did not work.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.
- Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include the informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

Settings that are not Home and Community-Based:

For 1115 demonstrations that furnish HCBS services, settings that are not home and community- based are defined at §441.301(c)(5) as follows:

- A nursing facility;
- An institution for mental diseases;
- An intermediate care facility for individuals with intellectual disabilities;
- A hospital; or
- Any other locations that have qualities of an institutional setting, as determined by the Secretary.

ATTACHMENT B

Behavioral Health (BH) Home and Community Based Services (HCBS) and Community Oriented Recovery and Empowerment (CORE) Services in HARPS

Behavioral Health HCBS
BH HCBS Assessment • BH HCBS Eligibility Brief Assessment • Plan of Care Development – Initial • Plan of Care Development – Ongoing
Habilitation Services
Non-medical transportation

• Employment Supports
  ○ Pre-Vocational Services
  ○ Transitional Employment
  ○ Intensive Supported Employment
  ○ Ongoing Supported Employment

• Education Support Services

*BH HCBS settings must adhere to the same HCBS setting qualities as listed in Attachment A.

Behavioral Health Community Oriented Recovery and Empowerment Services in HARPS and HIV SNPs

Behavioral Health CORE
• Psychosocial Rehabilitation (PSR) is designed to assist an individual in restoring their functional abilities to the greatest degree possible in settings where they live, work, learn, and socialize. Rehabilitation counseling, skill building, and psychoeducational interventions provided through PSR are used to support attainment of person-centered recovery goals and valued life roles. Approaches are intended to restore skills to overcome barriers caused by an individual's behavioral health disorder and promote independence and full community participation.

- Community Psychiatric Support and Treatment (CPST) includes goal-directed supports and solution-focused interventions with the intent to achieve person-centered goals and objectives. This is a multi-component service that consists of therapeutic interventions such as clinical counseling and therapy, which assist the individual in achieving stability and restoring functional skills. CPST addresses behavioral health barriers that impact daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community participation.
    - CPST is designed to provide mobile treatment services to individuals who have difficulty engaging in site-based programs, or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment. CPST allows for delivery of services within a variety of permissible off-site settings including, but not limited to, community locations where the individual lives, works, learns, and/or socializes.
- Empowerment Services – Peer Support (Peer Support) are non-clinical, peer-delivered services with focus on rehabilitation, recovery, and resilience. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural supports and community resources.
    - Peer Support must include the identified goals or objectives in the person's Individual Service Plan (ISP), with interventions tailored to the individual. These goals should promote utilization of natural supports and community services, supporting the person's recovery and enhancing the quality of their personal and family life. The intentional, goal-directed activities provided by this service emphasize the opportunity for peers to model skills and strategies necessary for recovery, thereby restoring the individual's skills and self-efficacy. These services are provided through the perspective of a shared personal experience of recovery, enhancing the individual's sense of empowerment and hope.
- Family Support and Training (FST) offers instruction, emotional support, and skill building necessary to facilitate engagement and active participation of the family in the individual's recovery process. The FST practitioner partners with families through a person-centered or person-directed, recovery oriented, trauma-informed approach.
    - Family is defined as the individual's family of choice. This may include persons who live with or provide support to a person, such as a parent, spouse, significant other, children, relatives, foster family, in-laws, or others defined as family by the individual receiving services. Family does not include individuals who are employed to care for the individual receiving services.

ATTACHMENT C
Mandatory Managed Long-Term Care/Care Coordination Model (CCM)

Mandatory Population: Dual eligible, age 21 and over, receiving community based long term care services for over 120 days, excluding the following:

- Nursing Home Transition and Diversion waiver participants;
- Traumatic Brain Injury waiver participants;
- Assisted Living Program participants; and
- Dual eligible that do not require community based long term care services.

Voluntary Population: Dual eligible, age 18 through 20, in need of community based long term care services for over 120 days and assessed as nursing home eligible. Non-dual eligible age 18 and older assessed as nursing home eligible and in need of community based long term care services for over 120 days.

The following requires CMS approval to initiate and reflects the enrollment of the mandatory population only.

I. Phase I and II: New York City and the suburbs

July 1, 2012 - Any new dual eligible case new to service, fitting the mandatory definition in any New York City County will be identified for enrollment and referred to the Enrollment

Broker for action.

- Enrollment Broker will provide with educational material, a list of plans/CCMs, and answer questions and provide assistance contacting a plan if requested.
- Plan/CCM will conduct assessment to determine if eligible for community based long term care.
- Plan/CCM transmits enrollment to Enrollment Broker.

In addition, the following identifies the enrollment plan for cases already receiving

care. Enrollment will be phased in by service type by borough by zip code in batches. People will be given 60 days to choose a plan according to the followingschedule.

July 1, 2012: Begin personal care cases in New York County

August 1, 2012: Continue personal care cases in New York County

September, 2012: Continue personal care cases in New York County and begin personal care in Bronx County; and begin consumer directed personal assistance program cases in New York and Bronx counties

October, 2012: Continue personal care and consumer directed personal assistance program cases in New York and Bronx counties and begin Kings County

November, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties

December, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties and begin Queens and Richmond counties

January, 2013: Continue personal care and consumer directed personal assistance program citywide.

February, 2013 (and until all people in service are enrolled): Personal care, consumer directed personal assistance program, citywide

March, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days citywide

March, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days in Nassau, Suffolk and Westchester counties

April, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days and long-term home health care program citywide

April, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days and long-term home health care program in Nassau, Suffolk and Westchester Counties

II. Phase III: Rockland and Orange Counties

June 2013: Dually eligible community based long term care service recipients in these additional counties as capacity

III. Phase IV: Albany, Erie, Onondaga and Monroe Counties

Fall 2013: Dually eligible community based long term care service recipients in these additional counties as capacity

IV. Phase V: Other Counties with capacity

Spring 2014: Dually eligible community based long term care service recipients in these additional counties as capacity

V. Phase VI:

Previously excluded dual eligible groups contingent upon development of appropriate program models:

- Nursing Home Transition and Diversion waiver participants;
- Traumatic Brain Injury waiver participants;
- Assisted Living Program participants; and
- Dual eligible that do not require community based long term care services.

ATTACHMENT D
List of Eligible Goods and Services Under BH HCBS Individual Directed Goods and Services

Non-treatment Goods and Services Eligible for Self-Direction
Non-Treatment Goods and Services may include the following:

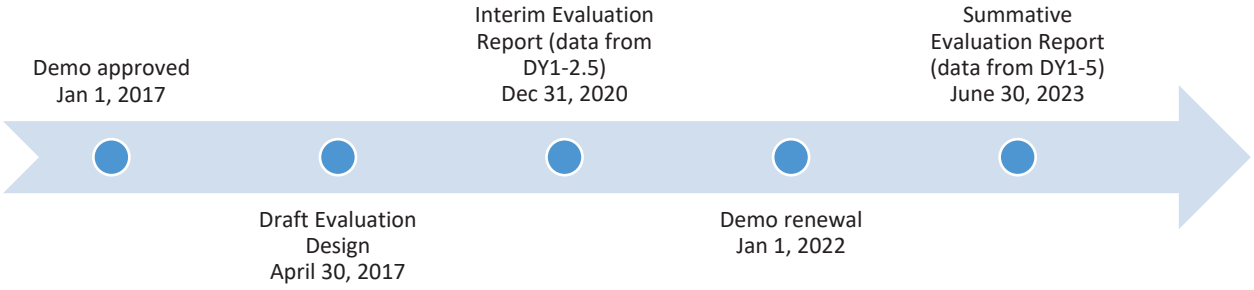
- Wellness activities
  - Gym/ health club membership
  - Wellness coaching
  - Smoking cessation tools/ education
  - Dental care
  - Eyeglasses/care
  - Out of network health/BH/specialty services
  - Family planning and sexual health education/ services
  - Acupuncture/pressure
  - Yoga classes/ meditation guidance
  - Massage/ reiki/ shiatsu/ tai chi instruction
  - Pet adoption funds, including appointments/resources related to pet health and maintenance
  - Workout equipment and clothing
  - Nutritional supplements and vitamins
- Occupational/ skills development
  - Computer literacy
  - Resume development
  - Interview preparation
  - PC/ communication technology
  - Personal preparation/ resources to prepare for interviews or to enhance confidence during employment, including purchase of a wardrobe or maintenance of personal hygiene (including but not limited to skin and hair care)
  - Resources for entrepreneurial development, including business cards, website development
  - Course Fees and Educational course fees and materials
- Transportation
  - Public transportation costs
  - Car repair/ maintenance
  - Bicycle and related costs
- In-home/ social/ community supports
  - Training and supports for daily living including cooking and nutrition classes, sequencing, time management, etc.
  - Housing start-up (down payments), non-recurring housing bills or costs related to home maintenance, including furniture or air conditioner
  - Groceries
  - Travel to and from family or social functions, including special trips to visit family members or friends
  - Meetings in the community with friends or family members at restaurants,

coffee houses, or other social venues, that promote the social inclusion of the participant
- Financial contributions at social activities including church services
- Registration fees for conferences, trainings, community activities
- Membership dues in groups, societies, guilds, leagues

ATTACHMENT E
Developing the Evaluation Design

Introduction
Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines
There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs
CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If

the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.

2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.
3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.
4. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure. Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.
2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
3. *Evaluation Period* – Describe the time periods for which data will be included.
4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration

during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate. The state also should include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.
6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
    c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
    d. Consider the application of sensitivity analyses, as appropriate.
7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes;
    b. No or minimal appeals and grievances;
    c. No state issues with CMS-64 reporting or budget neutrality; and
    d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

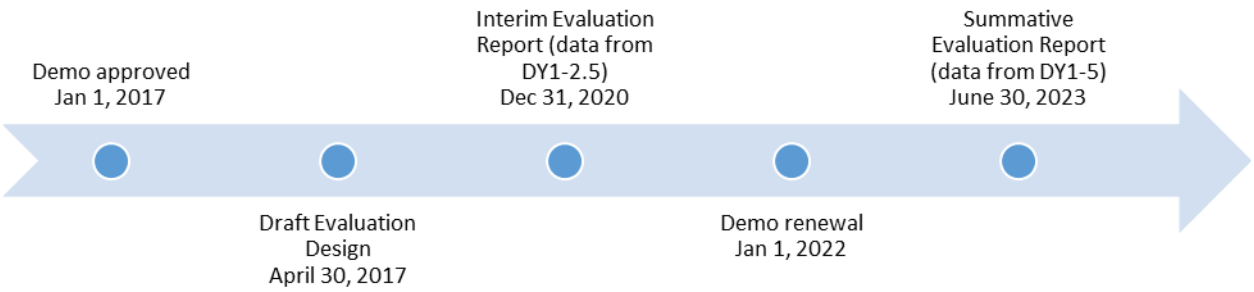
2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

Attachment F:
Preparing the Interim and Summative Evaluation Reports

Introduction
Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines
There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports
All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses,

which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When applying for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;

F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and,
J. Attachment(s).

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of titles XIX and XXI.
3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

4. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.
2. *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected.
4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.
5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.
6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2. If the state did not fully achieve its intended goals, why not?
3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

Attachment G:
Evaluation Design (Reserved)

Attachment H
SUD Implementation Plan
Approved January 9, 2024

OVERVIEW

This Implementation Plan is submitted in conjunction with the New York Department of Health submission of a substance use disorder (SUD) demonstration pursuant to Section 1115 of the Social Security Act. New York is committed to providing a full continuum of care for people with opioid use disorder (OUD) and other SUDs and expanding access and improving outcomes in the most cost-effective manner possible.

Goals:

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmissions is preventable or medically inappropriate for OUD and other SUDs; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

Milestones:

1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including medication assisted treatment (MAT);
5. Implementation of comprehensive treatment and prevention strategies to address opioid misuse and OUD; and
6. Improved care coordination and transitions between levels of care.

Section I – Implementation Plan Milestone Completion

This section contains information detailing New York's strategies for meeting the six milestones over the course of the demonstration. Specifically, this section:

1. Includes a summary of how, to the extent applicable, New York already meets each milestone, in whole or in part, and any actions needed to meet each milestone, including the persons or entities responsible for completing actions;
2. Describes the timelines and activities that New York will undertake to achieve the milestones; and

3. Provides an overview of future plans to improve beneficiary access to SUD services and promote quality and safety standards.

Milestones

1. **Access to Critical Levels of Care for OUD and Other SUDs**

New York offers a range of services at varying levels of intensity across a continuum of care because each type of treatment or level of care may be more or less effective depending on each beneficiary's individual clinical needs. To meet this milestone, New York's current SUD Medicaid treatment system includes coverage of the following:

- Screening, Brief Intervention and Referral to Treatment (SBIRT) Services
- Outpatient;
- Intensive Outpatient;
- Outpatient Rehabilitation
- Medication Assisted Treatment including Methadone Maintenance (medications, as well as counseling and other services, with sufficient provider capacity to meet the needs of Medicaid beneficiaries in the state);
- Ambulatory withdrawal management;
- Intensive LOCs in residential settings and withdrawal management;
- Intensive LOCs in inpatient hospital settings;
- Medically-managed and medically supervised withdrawal management;
- Residential Rehabilitative Services for Youth (RRSY); and
- Health Home for children and Adults with Serious Mental Illness, Serious Emotional Disturbance and Co-Occurring SUD.

This demonstration builds upon an extensive, existing array of New York Medicaid covered behavioral health (BH) services, including evidence-based services and will improve upon and enhance services that are currently covered only under non-Medicaid sources, including state funding and other federal funding.

New York Medicaid covers all ambulatory Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) LOCs, as well as medication-assisted treatment (MAT), residential and inpatient services and withdrawal management. New York's Medicaid state Plan includes authority for a complete continuum of care as approved in state Plan Amendment (SPA) #16-0004, 91-0039, 91-0075, 09-0034, 19-0017, 19-0013, 19-0018, 06-61, and 08-39. The Demonstration will permit DOH to provide critical access to medically necessary SUD treatment services in the most appropriate setting for the member as part of a comprehensive continuum of SUD treatment services.

The demonstration would permit DOH to provide medically necessary medical and BH care (including co-occurring mental health [MH] and SUD treatment services) in the most appropriate setting for individuals receiving residential and inpatient SUD treatment services. This approach is designed address the demonstration goals detailed below under Hypothesis and Evaluation, including improving health care outcomes for individuals with SUD (reducing

hospital emergency department use and inpatient admissions, reducing hospital readmissions, and improving the rates of initiation, engagement and retention in treatment).

New York Medicaid currently covers adult SUD residential services under approved state Plan Amendment #16-004. However, the state has not yet implemented reintegration services under that state Plan. New York will begin reimbursing for reintegration services delivered by providers whose qualifications are consistent with LOCADTR, state regulations, and the already approved state Plan Amendment. Reintegration is a phase of care in residential treatment that correlated to 3.1 in ASAM. People in this level of care benefit from ongoing rehabilitation and skill building to support recovery and move towards independent living. A reimbursement SPA will be submitted to update reimbursement methodologies.

The New York Office of Addiction Services and Supports (OASAS) directly operates 12 Addiction Treatment Centers and oversees over 1,600 addiction treatment programs. In addition, expanded regional programming including Centers of Treatment Innovation (COTIs), Open Access Centers and Recovery Community Centers, treat New Yorkers wherever they may be in their recovery journey.

Summary of All OASAS Services

LOCATDR Service Description	NYCRR Title 14	# of providers	# of facilities	# of beds / slots	Count Served Cohort CY2019	Avg Length of Stay (days) for CY 2019 Cohort	Vacancies as of 11/30/21 (Beds)	ASAM Level
Medically Managed Inpatient Detoxification	816	17	18	350	32,079	3.7	120	4-WM
Medically Supervised Inpatient Detoxification	816	23	26	703	32,769	4.1	318	3.7-WM
Inpatient Treatment	818	62	65	2,492	49,553	15.7	354	3.7
Residential Rehabilitation Services for Youth	818	7	9	240	955	108.8	65	3.7

Residential Services - Stabilization / Rehabilitation (w/o Reintegration)	820	17	32	1,154	6,724	50.3	268	3.5 / 3.3
Residential Services - Stabilization / Rehabilitation (with Reintegration)	820	17	35	1,849	4,892	110.9	352	3.5/3.3/3.1
Residential Services - Reintegration Only	820	15	29	730	977	201.8	107	3.1
Day Rehabilitation	822	28	35	NA	6,977	117.7	NA	2.5
Intensive Outpatient (Cohort Data is CY2021 Annualized)	822	28	40	NA	387	185.4	NA	2.1
Medically Supervised Outpatient Withdrawal	822	10	10	259	2,981	12.4	NA	2-WM
Outpatient Clinic	822	271	425	NA	158,158	185.4	NA	1
Opioid Treatment Program	822	56	103	40,886	54,976	481.2	NA	1

Residential Services - Intensive Residential	819	13	22	1,285	8,626	149.8	211	Comparable to ASAM 3.3
Residential Services - Community Residence	819	38	50	1,021	4,860	155.7	98	Comparable to ASAM 3.1
Residential Services - Supportive Living	819	22	27	659	1,965	209.2	159	Comparable to ASAM 3.1

This demonstration is necessary to address critical unmet needs for residential SUD treatment that continue to exist despite significant improvements to the publicly-funded treatment delivery system outside of Medicaid. state-only funds and federal Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funds are used to support some residential services for individuals enrolled in Medicaid.

Each residential program in the table above is certified to provide one or more of the phases of care based on population served, staffing, physical environment and expertise. Individuals are placed in the most appropriate phase of residential care and provided services that match that level. Programs are designated in the certification process to provide one or more of the phases.

Additional residential SUD services will be included under the Medicaid state Plan with this demonstration. This transition to Medicaid reimbursement of residential and inpatient IMD services will ensure access to a comprehensive, coordinated system of SUD care for children and adults in Medicaid. Most importantly, for some Medicaid-covered individuals in need of SUD treatment, there were limited options for residential community-based SUD treatment services.

The complete SUD benefit package includes support for evidence-based practices already implemented in the state, such as multi-systemic therapy (MST), Functional Family Therapy (FFT) and Multidimensional Family Therapy (MDFT) for children with SUD conditions. It also modernizes the SUD treatment benefit to include IMD levels of care that are currently outside of the benefit, but have always been a part of the treatment continuum that exists in LOCADTR criteria for outpatient, inpatient and residential treatment. Providers have been and continue to be trained using the most current edition of LOCADTR criteria to provide multi-dimensional assessments that inform placement and individualized treatment plans to increase the use of community-based and non-hospital residential programs and assure that inpatient hospitalizations are utilized appropriately for situations in which there is a need for safety, stabilization, or acute withdrawal management.

Below is a table that describes how New York meets Milestone 1 for Medicaid beneficiaries, including a variety of services at different levels of intensity across a continuum of care.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of outpatient services	New York Medicaid covers SUD outpatient treatment services under the following sections of the Medicaid State Plan using the LOCADTR level of care criteria: • Outpatient hospital (SPA 06-61, 08-39) • FQHC • Physician services • Rehabilitation services (3.1-a (3b-37).	All LOCADTR levels are covered.	No further action needed
Coverage of intensive outpatient services	New York Medicaid covers SUD intensive outpatient treatment services, including partial hospitalization, under the following sections of the state Plan: • Outpatient hospital • FQHC • Rehabilitation Services	All LOCADTR levels are covered.	No further action needed
Coverage of MAT (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state)	New York Medicaid covers MAT (for non-OUD and OUD) and associated counseling/services under the following sections of the state Plan: • Physician services • Rehabilitation Services • Medication-Assisted Treatment (MAT) 1905(a)(29) Page 3.1-a (8)	All MAT is covered.	No further action needed
Coverage of intensive levels of care in residential and inpatient settings	New York Medicaid covers residential SUD in a non- hospital setting under the Rehabilitative Services Option. (Page Attachment 3.1-A 3b-37(v)-(viii)) New York Medicaid covers the following inpatient SUD treatment: • Inpatient hospital services Inpatient hospital for individuals aged 65 or older in institutions for mental diseases • Inpatient psychiatric facility services for individuals under	New York Medicaid enrollees do not have access to residential services under the LOCADTR LOC for Reintegration (similar to ASAM 3.1). Under this demonstration, the state will begin authorizing Medicaid coverage of this residential level of care delivered in IMDs as providers enroll in	Within 6 months, New York will authorize and begin to reimburse for Medicaid individuals to receive services for the LOCADTR LOC for Reintegration services provided in an IMD. The state anticipates 50 providers to enroll within the first year.

	22 years of age	Medicaid.	

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of medically supervised withdrawal management	New York Medicaid covers medically supervised withdrawal management in a hospital and non-hospital setting. • Inpatient withdrawal management in a general hospital setting • Inpatient withdrawal management in a non-hospital setting • Ambulatory withdrawal management under the following authorities: • Outpatient hospital • Rehabilitative Free-standing services • FQHC services	All LOCADTR levels are covered.	No further action needed

2. <u>Use of Evidence-based, SUD-specific Patient Placement Criteria</u>

New York has implemented the LOCADTR, which is evidence-based, SUD-specific patient placement criteria. New York Medicaid has adopted a complete array of SUD treatment services using a national placement criteria system (e.g., LOCADTR) or national provider standards. Specifically:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, linked to the ASAM Criteria; and
- Utilization management approaches are implemented to ensure that

(a) beneficiaries have access to SUD services at the appropriate level of care,
(b) interventions are appropriate for the diagnosis and level of care, and
(c) there is an independent process for reviewing placement in residential treatment settings.

Below, New York identifies how it requires all providers to use the LOCADTR evidence-based, SUD-specific placement criteria to provide treatment that reflects diverse patient needs and evidence-based clinical guidelines. This table includes current and intended actions and associated timelines needed to meet Milestone 2 (*Use of evidence-based, SUD-specific patient placement criteria)*. This milestone has already been met.

Milestone Criteria	**Current State**	**Summary of Actions Needed**
Implementation of requirement that providers assess treatment needs based on SUD- specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines	New York providers are required to utilize assessments that are directly tied to the LOCATDR criteria for treatment planning. New York has implemented a universal training program for providers to assess treatment needs based on the LOCATDR's multi- dimensional tools and to base treatment needs on those assessments. New York requires all Medicaid SUD providers through regulation to use the for level of care (LOC) assessments using the LOCADTR, consistent with provider training. Under the regulations, providers are required to develop recommendations for placement in appropriate levels of care based on the LOCADTR and multi- dimensional assessments.	No further action needed
Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate level of care	Regardless of payor type, all providers are required to utilize the LOCADTR as the utilization management tool for all Medicaid SUD services, as well as the patient placement criteria to review residential placements using the LOCADTR placement criteria. New York has ensured that program standards are set for beneficiaries to have access to SUD services at the appropriate LOC based on the LOCADTR dimensions of care. New York already requires through MMCP contract language that for utilization management MMCPs use LOCADTR language consistent with provider training. All website, provider information and internal documentation are consistent with the LOCATR. OASAS has a website with a provider search function for Medicaid beneficiaries and providers at all LOCADTR LOCs.	No further action needed

Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and level of care	Today, MMCPs and FFS providers utilize the LOCADTR to review utilization for ambulatory, residential care and inpatient hospital care. New York has developed program standards to ensure that providers' interventions are appropriate for the diagnosis and each LOCADTR LOC. All Medicaid websites, criteria, manuals, and provider standards will consistently refer to the latest ASAM edition.	No further action needed
Implementation of a utilization management approach such that (c) there is an independent process for reviewing placement in residential treatment settings	The current Medicaid MMCPs already use the LOCADTR for residential and inpatient utilization review. MMCPs receive a copy of the LOCADTR report with clinical assessment information conducted by the provider. Plans have training on LOCADTR and complete LOCADTRs as necessary to independently review admissions. Oversight agency regulation of billing and certification requirements through 14 NYCRR Part 841, onsite chart reviews and general oversight of LOCADTR and placement as part of normal site review process. The placement criteria currently in use can be found at the following link: https://oasas.ny.gov/locadt r New York uses the LOCADTR for utilization review of Medicaid inpatient and residential placements. All website, provider information and internal documentation is consistent with the LOCADTR. Additionally, plans are prohibited by state law from requiring prior authorization for addiction services but conduct retrospective review to ensure services were clinically appropriate, consistent with LOCADTR. The current Medicaid MMCPs already use the LOCADTR for residential and inpatient utilization review. MMCPs receive a copy of the LOCADTR report with clinical assessment information conducted by the provider. Plans have training on LOCADTR and complete LOCADTRs as necessary to independently review admissions. Oversight agency regulation of billing and certification requirements through 14 NYCRR Part 841, onsite chart reviews and general oversight of LOCADTR and placement as part of normal site review process. The placement criteria currently in use can be found at the following link:	No further action needed

	https://oasas.ny.gov/locadtr New York uses the LOCADTR for utilization review of Medicaid inpatient and residential placements. All website, provider information and internal documentation is consistent with the LOCADTR. Additionally, plans are prohibited by state law from requiring prior authorization for addiction services, but can conduct retrospective review to ensure services were clinically appropriate, consistent with LOCADTR.	

3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Through this demonstration, New York will receive federal financial participation (FFP) for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as institutions for mental diseases (IMDs). To meet this milestone, New York will ensure that the following criteria are met:

- Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts that meet the LOCADTR criteria, which is a nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings;
- Implementation of a state process for reviewing residential treatment providers to assure compliance with these standards; and
- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

OASAS regulations and Medicaid policy manuals contain standards consistent with LOCADTR criteria for residential programs, including requirements for the particular types of services, hours of clinical care and credentials of staff for residential treatment. The policies already include a requirement that residential treatment providers offer MAT onsite or facilitate access offsite with a MAT provider not associated with the residential treatment owner.[10] New York will also continue to implement the process for initial certification and ongoing monitoring of residential treatment providers to ensure compliance with the state regulation requirements which are consistent with LOCADTR placement standards.

Below, New York already incorporates nationally recognized, SUD-specific LOCADTR program standards into their provider qualifications for residential treatment facilities through their regulations, policy manuals and other guidance to meet Milestone 3 (*Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities)*.

[10] 14 NYCRR 817.3(d)(1) and 14 NYCRR 800.4

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, contracts, or other guidance. Qualification should meet program standards in the LOCADTR, which is a nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings	OASAS regulations outline the types of services, hours of clinical care, and credentials of staff for residential treatment setting, which are consistent with the LOCADTR. Medicaid contracts reflect that residential providers must meet these requirements for residential programs, including requirements for the particular types of services, hours of clinical care and credentials of staff for residential treatment. 14 NYCRR 800.4; 14 NYCRR 810.7; 14 NYCRR 816; 14 NYCRR 817.3(d)(1); 14 NYCRR 818; 14 NYCRR 820 and 14 NYCRR 841.	n/a	No additional action needed.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards	All SUD residential providers are licensed by the New York OASAS. All SUD residential providers are monitored and certified to provide the LOCADTR LOC for which the provider is enrolled in the Medicaid program. The monitoring of the providers includes a review of the facility's infrastructure, as well as how the infrastructure is applied to ensure compliance with the state standards consistent with the LOCADTR and state regulations supporting	New York will continue to implement the process for initial certification and ongoing monitoring of residential treatment providers to ensure compliance with the state regulation requirements which are consistent with LOCADTR placement standards.	No additional action needed.

	the LOCADTR. The monitoring includes initial certification, monitoring and recertification. Additional oversight activities as described in 14 NYCRR Part 810 may include unannounced site visits or provider contacts including but not limited to: interim performance reviews, focused or targeted reviews, facility evaluations, fiscal audit or reviews, corrective action plan monitoring, cursory on-site visits, and/or accreditation surveys completed by nationally recognized accrediting organizations.		
Implementation of requirement that residential treatment facilities offer MAT onsite or facilitate access off-site	New York has in place a regulatory requirement that residential treatment facilities offer multiple versions of MAT on- site or facilitate access off-site (14 NYCRR 817.3(d)(1) and 14 NYCRR 800.4) All residential treatment providers offer at least one version of MAT on-site or facilitates access off-site.	None needed – New York currently meets criteria.	No additional action needed – New York currently meets criteria.

4. <u>Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD</u>

To meet this milestone, New York will complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment will determine the availability of treatment for Medicaid beneficiaries in each of these LOCs, as well as availability of MAT and medically supervised withdrawal management, throughout the state. This assessment will identify gaps in availability of services for beneficiaries in the critical LOCs and develop plans for enhancement of capacity based on assessments of provider availability.

To ensure there is necessary information regarding access to outpatient providers, OASAS maintains a website that is updated regularly. This report, which can be found at the following link https://webapps.oasas.ny.gov/providerDirectory/. The state also maintains a toll-free number called the HOPEline at 1-877-8-HOPENY where operators provide three referrals to assessment services in a caller's area.

The state maintains a treatment availability dashboard for outpatient and bedded programs as well that can be accessed at: https://findaddictiontreatment.ny.gov/ This dashboard allows the state to monitor capacity of all SUD treatment providers including MAT. It also allows New York residents to search for an open slot in a treatment program in their area. The treatment availability dashboard displays treatment programs with real-time availability for particular areas.

New York currently contracts for 98,835 adult SUD residential treatment beds across 214 providers. All but 5,712 of these certified SUD residential, withdrawal management and inpatient SUD treatment service providers have more than 17 beds and meet the definition of an IMD. See the table below for the number of beds and providers providing each non-Medicaid residential level of care in New York.

LOCATDR Service Description	NYCRR Title 14	# of Providers	# of Facilities	# of beds/ slots	Count Served Cohort CY2019	Avg Length of Stay (days) for CY 2019 Cohort	Vacancies as of 11/30/21 (Beds)	ASAM Level
Medically Supervised Inpatient Detoxification	816	20	22	646	29,919	4.1	292	3.7-WM
Inpatient Treatment	818	28	31	1,589	30,938	15.7	159	3.7
Residential Services - Stabilization / Rehabilitation (w/o Reintegration)	820	15	29	1,092	6,436	50.3	263	3.5 / 3.3
Residential Services - Stabilization / Rehabilitation (with Reintegration)	820	16	33	1,813	4,870	110.9	343	3.5/3.3/3.1
Residential Services - Reintegration Only	820	9	19	572	842	201.8	88	3.1
TOTAL / AVG			134	5,712		22.6		

In NYS, more than 78,600 patients were prescribed at least one buprenorphine prescription for outpatient treatment of OUD in 2019. The crude rate of buprenorphine prescribing for OUD increased by 28.5 percent from 314.8 per 100,000 population in 2016 to 404.5 per 100,000 in 2019. The rate was more than two times higher in NYS excluding NYC than that for NYC during 2016-2019.

The NYSDOH Buprenorphine Access Initiative began in July 2016 with the goal of increasing the number of healthcare practitioners certified to prescribe buprenorphine and thus, increase the number of patients receiving buprenorphine. In 2019 DOH AIDS Institute implemented a statewide AIDS Institute Provider Directory which includes a directory of buprenorphine prescribers. This website allows individuals to search for prescribers in their area by zip code and distance they are willing to travel. Coupled with clarifications done by DOH AIDS Institute and NYS education department a significant increase in waived buprenorphine providers in

NYS has occurred. Based upon the DEA record of waived buprenorphine providers in NYS, there has been an increase of 1,182 providers in 2018, with a total of 5,174 at the end of 2018 (Table 1b).

Table 1 Number of Buprenorphine-Waived Providers in NYS, by Type of Waiver

	2017	2018	2019
MD/DO- 30 patients	2,716	3,302	4,190
MD/DO- 100 patients	672	742	762
MD/DO- 275 patients	236	280	318
NP- 30 patients	287	567	928
NP- 100 patients	N/A*	69	143
NP- 275 patients	N/A*	N/A*	18
PA- 30 patients	81	185	282
PA- 100 patients	N/A*	29	62
PA- 275 patients	N/A*	N/A*	8
Total providers	3,992	5,174	6,711

** Note: NP/PAs could not prescribe in NYS until May 2017*

In NYS, the crude rate of patients who received at least one buprenorphine prescription for OUD increased between 2016 (314.8 per 100,000 population) and 2019 (404.5 per 100,000), representing a 29 percent increase (Figure 50). The rate was more than two times higher in NYS excluding NYC than in NYC during 2016- 2019. It is encouraging that more qualified practitioners have completed the required training and have received their SAMHSA DATA 2000 waiver and DEA X-designation so that they have the capacity to prescribe buprenorphine for the treatment of OUD. These qualified practitioners include physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs), Licensed Midwifes (LMs) and are in various settings increasing access for this life-saving medication.

The table below summarizes the current and future actions, including associated timelines, to meet Milestone 4 (*Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment)*. This milestone will be met within 12 months of Demonstration approval. *Note: It is necessary to ensure the complete implementation of the new service array in Medicaid prior to the capacity assessment being conducted.*

The anticipated penetration rate and geographic distributions of providers at each LOC is noted where available.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Completion of assessment of the availability of providers enrolled in Medicaid and	The state maintains a treatment availability dashboard for outpatient and bedded programs as well that can be accessed at: https://findaddictiontreatment.ny.	New York will examine the potential to enhance access monitoring	OASAS will work with NYS DOH to complete an assessment of providers accepting new patients (within 1 year of

accepting new patients in the following critical levels of care throughout the state including those that offer MAT: • Outpatient Services; • Intensive Outpatient Services; • Medication Assisted Treatment(medications as well as counseling and other services); • Intensive Care in Residential and Inpatient Settings; • Medically Supervised Withdrawal Management.	gov/ This dashboard allows the state to monitor capacity of all SUD treatment providers including MAT. It also allows New York residents to search for an open slot in a treatment program in their area. The treatment availability dashboard displays treatment programs with real-time availability for all regions across the state.	reporting under the Demonstration, including the provision of data related to Medicaid enrolled providers accepting new patients This initiative will leverage the current dashboard for ongoing access monitoring and recruitment and enrollment of new facilities as needed.	demonstration approval).

5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Misuse and OUD

To meet this milestone, New York will ensure that the following criteria are met:

1. Continue efforts to increase utilization and improve functionality of the NYS Prescription Monitoring Program
2. Continue efforts to expand interstate PMP data sharing and PMP-EHR integration.
3. Provide reference to relevant opioid prescribing guidelines along with other interventions such as practitioner-focused training programs, to prevent and/or reduce prescription drug misuse
4. Expanded coverage of and access to naloxone for overdose reversal

Part of New York State Department of Health's (NYSDOH) efforts to address the opioid and prescription medication crisis includes several mandates that are focused on the practitioner's role in prevention or risk reduction. NYSDOH requires practitioners who prescribe controlled substances to consult the NYS PMP Registry when writing prescriptions for Schedule II, III, and IV controlled substances. The data that populates the registry (dispensing data for Schedule II, III, IV, and V controlled substance prescriptions) is required to be submitted to New York state within 24 hours of dispensing. NYSDOH has also limited the initial prescribing of opioids for acute pain to no more than a seven-day supply of any schedule II, III, or IV opioid, within the scope of a practitioner's professional opinion or discretion. In July 2016, New York state limited the initial prescribing of opioids for acute pain to no more than a 7- day supply.[11] As a result, opioid prescriptions for more than a 7-day supply decreased steadily, from 28.7 percent in the first

[11] New York State Public Health Law Article 33 Section 3331 (5).https://www.nysenate.gov/legislation/laws/PBH/3331

quarter of 2017 to 15.3 percent in the fourth quarter of 2019.[12]

Additionally, NYSDOH has required by mandate that practitioners who treat humans and have a DEA registration number to prescribe controlled substances, as well as medical residents who prescribe controlled substances under a facility DEA registration number, must complete at least three hours of course work in pain management, palliative care, and addiction. These efforts, in addition to referral to relevant opioid prescribing guidelines assist practitioners in engaging in informed prescribing practices and improves their ability to recognize areas of concern related to patient patterns of behavior.

Attachment A describes the state's plans for enhancing its health IT infrastructure to improve the NYS Prescription Monitoring Program (PMP) as part of the state's efforts to address SUD.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid misuse	Centers for Medicare & Medicaid Services (CMS) issued guidance to the states in 2019 related to implementation of the Medicaid Drug Utilization Review (DUR) provisions that were included in Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT Act.[13] New York has amended the Medicaid State Plan to reflect the new Drug Utilization Review provisions required in federal law. The NYRx program has implemented opioid clinical edits such as requiring prior authorization for the following: 1. Initially prescribing >7-day supply of an opioid for acute pain. 2. ≥50 MME per day of an opioid for opioid-naïve patients. 3. ≥90 MME of an opioid per day to manage non-acute pain (>7 days). Excluded are patients diagnosed with cancer, sickle cell disease and/or in hospice.	NYSDOH (BNE and Office of Drug User Health) are currently working on revisions to the mandated prescriber training. This includes updating standards, guidance, language, and the addition of harm reduction concepts.	A revised version of the provider training will be completed in August 2023.

[12] New York State Opioid Annual Report 2020. https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2020.pdf

[13] CMS Informational Bulletin: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/cib080519-1004_64.pdf

	4. Initiation of opioid therapy in patients currently on established benzodiazepine therapy. 5. Initiation of opioid therapy for patients on established opioid dependence therapy. 6. Initiation of long-acting opioid therapy in opioid-naïve patients.		
Expanded coverage of, and access to, naloxone for overdose reversal	NYS has taken a number of steps over the past decade to make naloxone more widely available, including: expanded efforts related to addressing opioid overdose through Article 33, Title 1 Section 3309. This multi-pronged approach focuses on building overdose response capacity within communities throughout the state. The core of this program is for community laypersons to be trained by organizations registered with the NYSDOH to administer naloxone (an opioid antagonist also known by the brand name Narcan) in the event of a suspected opioid overdose. • There are currently more than 800 registered Community Opioid Overdose Prevention (COOP) programs, with over half a million individuals trained by them since the initiative's inception in 2006. Of these, 78,000 were public safety personnel and the rest were community responders. • In 2019, there were 1,558 naloxone administration reports by law enforcement (LE) to the NYSDOH and 2,749 reports by COOP programs. • In total, including unique administrations by Emergency Medical Services (EMS) agencies, there were 16,710 reported naloxone administrations in NYS in 2019. There were 12,403 unique naloxone administrations reported electronically by EMS	None needed – New York currently meets criteria.	None needed – New York currently meets criteria.

	agencies during 2019, about a 10 percent decrease statewide from 13,724 administrations in 2018, with a seven percent decrease in NYC and a 13 percent decrease in NYS excluding NYC. In 2011, New York implemented a Good Samaritan law which allows individuals to seek emergency assistance in the case of an overdose without fear of being charged or prosecuted for possession of a controlled substance under 8 ounces, alcohol, marijuana, drug paraphernalia or sharing substances.[14] New York has a non-patient specific prescription for naloxone with pharmacy dispensing protocol appliable to all NYS registered pharmacists. Naloxone available to all addiction and mental health providers to use and distribute to communities that they serve through a direct order process. A naloxone copayment assistance program to cover up to $40 in prescription co-payments to minimize out of pocket expenses. Require pharmacies with 20 or more locations to have a non-patient specific prescription with an authorized health care professional or register as an opioid overdose prevention program. Scope of practice protections for obtaining, administering, and possession of naloxone for licensed individuals.		

[14] Good Samaritan Law was enacted as Chapter 154 of 2011; Publicly available brochure can be found at: https://www.health.ny.gov/publications/0139.pdf

	Yearly co-prescribing requirements for patients prescribed an opioid. Establishment of guidelines for onsite opioid overdose response capacity in nightlife establishments.		
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	Since 2012, New York state has required most prescribers to consult the NYS PMP Registry when writing prescriptions for Schedule II, III, and IV controlled substances. Establishing a duty to consult ensures practitioners have a fuller picture of their patient's controlled-substance history, which can inform treatment decisions, especially where practitioners recognize high risk patient behaviors. Additionally, NYS requires that data for all Schedule II, III, IV, and V controlled substance prescriptions dispensed by state- licensed pharmacies and dispensing practitioners be submitted to New York state within 24 hours. The requirement for data submission within 24 hours of dispensing makes helps to ensure that the data within the PMP registry is timely and accurate.	The Bureau of Narcotic Enforcement (BNE), within NYSDOH is working to enhance the NYS PMP Registry to improve utilization and functionality. BNE will continue to provide the MME calculator as resource for practitioners to identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.	BNE completed its technical build in March 2023 and released the new format in late May 2023. Within 6-9 months of release, BNE will conduct stakeholder engagement with PMP users to test system development and provide additional feedback regarding functionality. BNE continues to work with the Governance Board to aid in identification of state partners for interstate data sharing, as well as expand system knowledge to support NYSDOH's growth in the area of PMP-EHR integration.

	• In 2021, NYS implemented a Morphine Milligram Equivalents (MME) calculator. Calculating the Total Daily MMEs of opioids helps practitioners to identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose. • BNE, within NYSDOH has managed interstate PMP data sharing through the PMP Interconnect (PMPi) since 2015. In June 2021 BNE began interstate data sharing through the RxCheck hub. As of March 2022, BNE has data sharing agreements with 34 states, as well as Puerto Rico, Washington DC, and Military Health • Services through the PMPi and RxCheck hubs. • BNE has been working on a pilot project to integrate NYS PMP data into healthcare system electronic health records. • As of May 2022, BNE has initiated the process for PMP data sharing and EHR integration with the US Department of Veterans Affairs (VA). Under Public Health Law (PHL) §3309-A (3), prescribers licensed under Title Eight of the Education Law in New York who are licensed to treat	BNE is currently working on project to redesign the PMP Registry patient search landing page. The enhancements will include an indicator that notes the type of medication prescribed (Opioid, Benzodiazepine, or Stimulant), whether the prescription is current, a highly visual summary dashboard that notes the number of pharmacies or practitioners visited by the patient in the past 90 days, and how many prescriptions are present for Opioid, Benzodiazepine, or Stimulant to assist the practitioner in avoiding overlapping prescriptions that could lead to overdose. Ultimately these visual indicators will aid practitioners in identifying patient risk behaviors and assist in identifying patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.	A revised version of the provider training will be completed in August 2023.

	humans and who have a DEA registration number to prescribe controlled substances, as well as medical residents who prescribe controlled substances under a facility DEA registration number, must complete at least three hours of course- work in pain management, palliative care, and addiction. Education must cover the following topics: New York state and federal requirements for prescribing controlled substances; pain management; appropriate prescribing; managing acute pain; palliative medicine; prevention, screening and signs of addiction; responses to abuse and addiction; and end of life care. BNE, within the NYSDOH, and in partnership with the SUNY University at Buffalo offers an accredited training to meet the mandatory Opioid Prescriber Education training needs.[15] NYS OASAS by regulation and guidance, requires providers to educate about overdose prevention and must make Naloxone available to all patients, prospective patients. 14 NYCRR §800.6. Guidance can be found at this link: https://oasas.ny.gov/system/files/documents/2020/05/naloxone-prescribing.pdf	BNE continues to identify new states with which to develop data sharing agreements and will continue to explore the capacity of the RxCheck hub to further interstate interoperability. The PMP-EHR integration pilot project has demonstrated proof of concept and BNE is working to expand the number of sites engaged in PMP-EHR integration. BNE is exploring multiple options to meet this goal. NYSDOH (BNE and Office of Drug User Health) are currently working on revisions to the mandated prescriber training. This includes updating standards, guidance, language, and the addition of harm reduction concepts.	

6. <u>Improved Care Coordination and Transitions between Levels of Care</u>

[15] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

New York will implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD and other SUDs, with community-based services and supports following stays in these facilities. The table below outlines New York's current procedures for care coordination and transitions between LOCs to ensure seamless transitions of care and collaboration between services, including:

1. Current content of specific policies to ensure these procedures;
2. Specific plans to help beneficiaries attain or maintain a sufficient level of functioning outside of residential or inpatient facilities; and
3. Current policies or plans to improve care coordination for co-occurring physical and mental health conditions.

New York has multiple interventions for coordinating the care of individuals with SUD and transitioning between LOCs including, but not limited to, facility credentialing, discharge, referral and transition requirements, and care management initiatives at DOH and OASAS. OASAS Providers utilize LOCADTR continuing care module to conduct ongoing assessments on the appropriateness of a level of care and to determine subsequent levels of care. OASAS has also utilized state Opioid Response dollars to support regional networks designed to improve successful transitions between residential and outpatient settings. Additionally grant funding has been utilized to support transportation initiatives which assist individuals with making successful connections to care.

Under the demonstration, New York will utilize the health home model and strengthen the transition management component for SUD populations between LOCs. DOH and OASAS will create a clear delineation of responsibility for improved coordination and transitions between LOCs to ensure individuals receive appropriate follow-up care following residential treatment.

In addition, under the demonstration, in order to ensure improved care coordination and transitions between LOCs, New York will also monitor access and healthcare outcome measures by demographic information, including race and ethnicity. In addition, New York intends to implement coverage of enhanced individualized care coordination for individuals with SUD that is designed to identify, prevent, and address health inequities and challenges related to social determinants of health. New York state will evaluate the use of peers and other care connection mechanisms to ensure improved care coordination and overall health outcomes for individuals in care.

This milestone will be met within 12 to 24 months of demonstration approval.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities Additional policies to ensure coordination of care for cooccurring physical and mental health conditions	New York has multiple interventions for coordinating the care of individuals with SUD and transitioning them between LOCs, including, but not limited to, facility credentialing, discharge planning requirements (including but not limited to needed referrals for services and medication continuation if appropriate, appointment times/dates) and care management initiatives with MCCPs. Service coordination in all ASAM LOCs is required. Service coordination, includes, but is not limited to, provider-specific and LOC-specific activities that enhance and improve linking members between Medicaid treatment services and enhance and improve the likelihood of engagement in treatment.	Under the demonstration, OASAS will include all levels of services, including those over 16 beds in both managed care and fee for service environments. This will allow service recipients to obtain the full continuum of services as they progress in their recovery without interruption and will improve coordination and transitions between LOCs to ensure that individuals receive services and supports following stays in facilities and are retained in care. This will be done through increased clinical guidance and technical assistance, as well as data monitoring. There will also be increased case management staff/discharge planning staff as providers transition into the requirements of Part 820 regulations for service delivery and receive technical assistance and trainings/guidance from state Agency staff. 14 NYCRR Part 820 provides the staffing, programmatic and clinical requirements for the operation of a community based residential program providing stabilization, rehabilitation or reintegration services. MCCPs will be responsible for all residential levels of care which will allow them to coordinate services through an entire episode of care and provide care management. Providers will have an	OASAS will improve discharge planning and transition planning in the residential and ambulatory LOCs using LOCADTR standards within 12 months of Demonstration approval. To improve care coordination, OASAS will provide technical assistance, engage in ongoing review and updating of guidance as issues are identified. OASAS will also work with providers as they transition to 820 service delivery mechanism around staffing and programming to meet regulatory standards and program guidance that has been issued. These actions will be completed on an as needed basis and do not require statutory revision. Future state will be achieved by implementing existing regulatory requirements that increase staff responsible for coordinating care and improving transitions to community services, including transitional planning. The state will also provide additional technical assistance to MCCPs on 820 reintegration level of

		increased capacity to provide care management due to increase in care management staffing to better follow individuals to the next level of care or for a period post-discharge to ensure that linkages have been made.	care decisions within LOCADTR to ensure plans and providers are using the tool to fidelity.

Section II – Implementation Plan Administration

Please provide the contact information for the state's point of contact for the Implementation plan.

Name and Title: Pat Lincourt, Associate Commissioner
Email Address: Pat.Lincourt@oasas.ny.gov

Section III – Implementation Plan Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

Attachment A: Template for Substance Use Disorder Health Information Technology Plan
Attachment A Section I.

As a component of Milestone 5, Implementation of Strategies to Increase Utilization and Improve Functionality of PDMPs, in SMDL 17- 003, states with approved Section 1115 Substance Use Disorder (SUD) demonstrations are generally required to submit a SUD Health Information Technology (IT) Plan as described in the Special Terms and Conditions (STCs) for these demonstrations within 90 days of demonstration approval. The SUD Health IT Plan will be a section within the state's SUD Implementation Plan Protocol and, as such, the state may not claim federal financial participation for services provided in Institute for Mental Disease until the SUD Health IT Plan has been approved by CMS.

In the event that the state believes it has already made sufficient progress with regards to the health IT programmatic goals described in the STCs (i.e., PMP functionalities, PMP query capabilities, supporting prescribing clinicians with using and checking the PMP, and master patient index and identity management), it must provide an assurance to that effect via the assessment and plan below (see Table 1, "Current State"). SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PMP

The specific milestones to be achieved by developing and implementing a Health IT Plan that can be used to address SUD include:

- Enhancing the health IT functionality to support PMP interoperability and integration.
- Enhancing and/or supporting clinicians in their usage of the state's PMP through improved functionality, education, and prescribing guidelines.

The state should provide CMS with an analysis of the current status of its health IT infrastructure "ecosystem" to assess its readiness to support PMP interoperability. Once completed, the analysis will serve as the basis for the health IT functionalities to be addressed over the course of the demonstration — or the assurance described above.

The Health IT Plan should detail the current and planned future state for each functionality/capability/support — and specific actions and a timeline to be completed over the course of the demonstration — to address needed enhancements. In addition to completing the summary table below, the state may provide additional information for each Health IT/PMP milestone criteria to further describe its plan.

Table 1. State Health IT/ PDMP Assessment and Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
5. *Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and Opioid Use Disorder, that is:* • Enhance the state's health IT functionality to support its PDMP. Enhance and/or support clinicians in their usage of the state's PDMP	Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP and supports to enhance clinicians' use of the state's health IT functionality to achieve the goals of the PDMP.	Provide an overview of plans for enhancing the state's PDMP, related enhancements to its health IT functionalities and related enhancements to support clinicians' use of the health IT functionality to achieve the goals of the PDMP	Specify a list of action items needed to be completed to meet the Health Information Include timeframe for completion of each action item
PDMP Functionalities			
Enhancing and/or supporting clinicians in their usage of the state's PMP through improved functionality.	• NYSDOH provides access to the NYS PMP Registry 24 hours/day, 7 days a week. Through the PMP Registry practitioners can review the controlled substance history of their patients, identify prescriptions prescribed by the searching practitioner or by other practitioners, designate a designee to search on their behalf, review their own prescription writing history, their search history, and review the searching history of their designees. • The MME calculator provides an opioid dosage's equivalency to morphine. Calculating the	Within the next two-years (2022-23) BNE plans to incorporate two phases of revisions into the PMP Registry patient search landing page. These enhancements are intended to enhance the functionality and usability of the PMP Registry. These will include an indicator that notes the type of medication prescribed (Opioid, Benzodiazepine, or Stimulant), whether the prescription is current, a highly visual summary dashboard that notes the number of pharmacies or practitioners visited by the practitioner in the past 30 days, and how many prescriptions are present for Opioids, Benzodiazepines, or Stimulants to assist the practitioner in avoiding	Through combined support from NYSDOH and the CDC funded Overdose Data to Action Grant, BNE will work with NYS ITS to build out the technical architecture. BNE plans to conduct stakeholder engagement with PMP users to test system functionality and provide additional feedback regarding functionality.

	MME allows for a standard for comparing different opioids and provides a tool for gauging the overdose potential of the amount of opioid that is being given to an individual. The MME calculator also assists the practitioner in identification of patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.	overlapping prescriptions that could lead to overdose. Ultimately these visual indicators will aid practitioners in identifying patient risk behaviors and assist in identifying patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.	

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Enhancing and/or supporting clinicians in their usage of the state's PMP through education.	• BNE has provided a series of demonstration tutorials intended to expand practitioners' capacity to access, use, and understand the functionality of the NYS PMP Registry. There are four trainings available focused on how to use and run reports, reporting suspicious activity, appointing designees, and a training geared toward residents and interns prescribing opioids under a medical teaching facility DEA registration number. • BNE, in partnership with the SUNY University at Buffalo offers two trainings targeted for physicians, physician assistants, nurse practitioners, and pharmacists. One is an accredited training to meet the educational requirements for the mandated Opioid Prescriber Education course work. The second is an overview training regarding the essential components of the NYS Prescription Monitoring Program.	BNE is working on an additional training series for pharmacists and dispensing vendors related to data submission to the PMP Registry and error correction to ensure the timeliness and accuracy of PMP data. Training development will be ongoing for the next two years. BNE is currently updating the mandated Opioid Prescriber Education training, with a target for completion within the next year.	This work is scheduled and continues on a routine basis. It requires meetings with internal BNE partners. This work is being done in collaboration with the NYSDOH Office for Drug User Health and the State University of New York (SUNY) at Buffalo (UB). Scheduled work group meetings will be held to review and revise content and provide feedback to UB.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Enhanced interstate data sharing.	• BNE, within NYSDOH has managed interstate PMP data sharing through the PMP Interconnect (PMPi) since 2015. In June 2021 BNE began interstate data sharing through the RxCheck hub. As of March 2022, BNE has data sharing agreements with 34 states, as well as Puerto Rico, Washington DC, and Military Health Services through the PMPi and RxCheck hubs. States may not participate in interstate data sharing due to several factors, with the most common barrier being: • A state is focusing on connecting with their border states first. • A state is currently transitioning to a new PDMP system. • A state has prioritized other PDMP projects over interstate connectivity. BNE has been working on a pilot project to integrate NYS PMP data into healthcare system electronic health records. As of May 2022, BNE initiated the process for EHR integration with the US Department of Veterans Affairs (VA).	BNE continues to identify new states with which to develop data sharing agreements and will continue to explore the capacity of the RxCheck hub to further interstate interoperability.	BNE continues to work with the Governance Board to aid in identification of state partners for interstate data sharing, as well as expand system knowledge to support NYSDOH's growth in the area of PMP-EHR integration. BNE will work with the VA and their integration vendor to ensure NYSDOH receives appropriate audit files in order for BNE to meet their responsibility in monitoring PMP access and use.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
PMP-EHR Integration. Enhanced clinical workflow for prescribers and other state and federal stakeholders.	• BNE has been working on a pilot project to integrate NYS PMP data into healthcare system electronic health records. As of May 2022, BNE initiated the process for EHR integration with the US Department of Veterans Affairs (VA).	The PMP-EHR integration pilot project had demonstrated proof of concept and BNE is working to expand the number of sites engaged in PMP-EHR integration. BNE is exploring multiple options to meet this goal.	BNE continues to work with the Governance Board to aid in identification of state partners for interstate data sharing, as well as expand system knowledge to support NYSDOH's growth in the area of PMP-EHR integration.
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange.	In previous years BNE explored PMP data sharing using health information exchanges (HIE) through the Regional Health Information Organizations (RHIOS) in NYS. At the time the RHIOs were not compatible with NYS security requirements. This resulted in NYSDOH exploring PMP-EHR integration, rather than data sharing through HIE. Currently, BNE is not supporting PMP data integration through HIE, though there is potential to revisit this in the future.	Potential exploration of the feasibility of PMP data sharing through HIE.	Potential exploration of the feasibility of PMP data sharing through HIE.
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow/business processes to better support clinicians in accessing the PMP prior to prescribing an opioid or other controlled substance to address the issues which follow	BNE, within the NYSDOH has demonstrated capacity to integrate PMP data into a healthcare system's EHRs BNE has initiated the process for EHR integration with the US Department of Veterans Affairs (VA).	The PMP-EHR integration pilot project had demonstrated proof of concept and BNE is working to expand the number of sites engaged in PMP-EHR integration. BNE is exploring multiple options to meet this goal, including the use of RxCheck as a method for supporting PMP-EHR integration.	BNE will partner with federal and state partners through the Governance Board membership to identify additional options for expanding NYSDOH's PMP-EHR integration project.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	In previous years BNE explored PMP data sharing using health information exchanges (HIE) through the Regional Health Information Organizations (RHIOS) in NYS. At the time the RHIOs were not compatible with NYS security requirements. This resulted in NYSDOH exploring PMP-EHR integration, rather than data sharing through HIE. Currently, BNE is not supporting PMP data integration through HIE, though BNE is exploring the feasibility to revisit this in the future.	BNE is looking at the potential feasibility of revisiting PMP data sharing through HIEs.	There is potential for NYSDOH to revisit the potential for integration through HEIs, but this is not a current active project.
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP — prior to the issuance of an opioid prescription	The Bureau of Narcotic Enforcement (BNE), within NYSDOH is working to enhance the NYS PMP Registry to improve utilization and functionality. In 2021 NYS implemented a Morphine Milligram Equivalents (MME) calculator. Calculating the Total Daily MMEs of opioids helps practitioners to identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce	Within the next two-year (2022-23) BNE plans to incorporate two phases of revisions into the PMP Registry patient search landing page. These will include an indicator that notes the type of medication prescribed (Opioid, Benzodiazepine, or Stimulant), whether the prescription is current, a highly visual summary dashboard that notes the number of pharmacies or practitioners visited by the practitioner in the past 30 days, and how many prescriptions are present for Opioids, Benzodiazepines, or Stimulants to assist the practitioner in avoiding overlapping prescriptions that	BNE will work with NYS ITS to build out the technical architecture. BNE will conduct stakeholder engagement with PMP users to test system development and provide additional feedback regarding functionality.

	risk of overdose.	could lead to overdose. Ultimately these visual indicators will aid practitioners in identifying patient risk behaviors and assist in identifying patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.	

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The NYS PMP is not currently using a master patient index. The PMP is primarily used as one of many tools to support clinical decision making and is not currently used for tracking purposes.	If there is a future role for the NYS PMP it will need to be identified in collaboration with the Bureau of Narcotic Enforcement.	If there is a future role for the NYS PMP it will need to be identified in collaboration with the Bureau of Narcotic Enforcement.
Using PMP Data to aid in efforts to manage Medicaid payments for opioids			
Leverage the above functionalities/ capabilities/ supports (in concert with any other state health IT, technical assistance or workflow effort) to provide support tools for practitioners to minimize the risk of inappropriate opioid overprescribing which can aid in management of efforts to mitigate inappropriate opioid payments by Medicaid inappropriately pay for opioids	Basic and advanced functionality of PMP allows practitioners to have an additional tool for their clinical decision making related to controlled substance providing. NYS Law related to 7-day supply also serves as a mechanism to decrease overprescribing. Practices can use Automated at Point-of-Service for Medicaid FFS to limit initial opioid prescriptions for a 7-day supply consistent with NYS Law.	Understanding where PMP data, NYS laws, and federal guidance, in collaboration with Medicaid health IT systems can work together to inform prescribing practices.	

Attachment I
SUD Monitoring Protocol (Reserved)

Attachment J
HRSN Implementation Plan (Reserved)

Attachment K
Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services Protocol

Attachment L
Medicaid Hospital Global Budget Initiative Implementation Protocol (Reserved)

Attachment M
Provider Rate Increase Attestation Table (Reserved)

Attachment N
Approved List of DSHPs

Program	Description	DSHP-Eligible Expenditures
Area Health Education Centers (AHEC)	The New York State Area Health Education Center (NYS AHEC) System is a workforce development initiative whose mission is to increase the diversity of qualified healthcare professionals by recruiting and training individuals of all races and ethnicities, with a special emphasis on medically underserved areas in both rural and urban communities.	$8,800,000
Doctors Across New York (DANY) Diversity in Medicine	The DANY Diversity In Medicine program provides financial assistance to help train a diverse medical workforce in New York state.	$6,220,000
DANY Physician Loan Repayment and Practice Support	Doctors Across New York (DANY) provides financial assistance to help train and place physicians in underserved communities in a variety of settings and specialties to care for New York´s diverse population.	$54,420,000
Health Care Workforce Bonus (HWB) Program	Front line health care and mental hygiene practitioners, technicians, assistants, and aides earning less than $125,000 annually, who provide hands on health or care services to individuals.	$766,998,088
Health Workforce Retraining (Increase Training Capacity)	Grant funding for eligible organizations that seek to train or retrain health industry workers for new or emerging positions in the health care delivery system. transitions, reduce avoidable hospital readmissions and emergency room visits.	$28,186,550
Nurses Across New York (NANY)	The NANY initiative is designed to help train and place nurses (RNs and LPNs) in underserved communities, in a variety of settings and specialties, to care for New York's diverse population.	$12,000,000
Vital Access Providers Assurance Program (VAPAP)	The VAPAP program provides state-only support for facilities in severe financial distress to enable these facilities to maintain operations and provision of vital services while they implement longer-term solutions to achieve sustainable health care service delivery.	$2,404,793,968
Alzheimer's Caregiver Support	Designed to support caregivers and people with dementia in the community using evidence-based strategies. Takes a two-pronged, systems approach to the investment—both focusing on community support while also equipping the medical system to provide early diagnoses, quality care management, and linkages to community services.	$105,468,000

Cancer Services	The Cancer Services Program (CSP) provides breast, cervical and colorectal cancer screenings and diagnostic services at no cost to people who live in New York state, lack health insurance or have health insurance with a cost share that may prevent a person from obtaining screening and/or diagnostic services, and meet income eligibility/age requirements.	$89,300,000
CSEA Buy-in	Grants to Civil Service Employee Association (CSEA) Local 1000, AFL-CIO to reduce the cost of providing health insurance, dental and vision benefits to covered child care providers.	$13,200,000
Elderly Pharmaceutical Insurance Coverage (EPIC)	The Elderly Pharmaceutical Insurance Coverage Program provides secondary prescription drug coverage to Medicare-eligible individuals, assisting with drug costs after any Medicare Part D deductible is met and Part D premiums for low income individuals.	$250,068,000
End of AIDS	Funding for Ending the Epidemic supports a range of activities, including but not limited to services delivered through contracts with providers, local health departments, community-based organizations, and a review agent; educational and awareness activities; enhanced surveillance; medications for uninsured persons; and expenses associated with linkage and retention collaboratives.	$60,000,000
Expanded In-home Services for the Elderly (EISEP)	EISEP services include non-medical in-home services such as housekeeping, personal care, respite, case management, and related services (such as emergency response systems). EISEP services support and supplement informal care provided by clients' families. Clients are required to share the cost of services, based on income. These costs are determined by a sliding scale and range from no-cost to full-cost.	$20,000,000
MLTC Ombudsman	ICAN (Independent Consumer Advocacy Network) is a group of nonprofit advocacy organizations, independent of the New York State Department of Health or any health insurance plan, which can: Answer Medicaid enrollee questions and give advice about MLTC plans for people who receive Medicaid or Medicare and long-term care; Solve problems between an enrollee's plan and providers (for example doctors, hospitals, and pharmacist); and Help enrollees file a complaint or appeal.	$20,000,000

Newborn Screening	Newborn screening refers to medical tests, the majority of which are genetic, performed to identify babies with certain disorders, which without intervention, may permanently impact newborns and their families. Early recognition and treatment of most of these disorders leads to a better outcome for the newborn. The Newborn Screening Program's goal is to help affected babies live as long and normal of a life as possible. The Newborn Screening Program effectively identifies babies with certain disorders and is required for all newborns born in New York state unless the parents confirm, in writing, that they have a religious objection.	$38,941,504
NY Connects	NY Connects is a locally based No Wrong Door (NWD) system that provides one stop access to free, objective, comprehensive information and assistance on long term services and supports for people of all ages or with any type of disability. The NY Connects NWD System is administered through a collaboration between the Area Agencies on Aging (AAAs), Local Departments of Social Services (LDSS), and six regionally contracted Independent Living Centers (ILCs).	$95,600,000
Obesity - Diabetes Prevention Programs	The Department of Health works with many partners and contractors to develop and implement a range of obesity prevention programs in community, child care, school and heath care settings.	$23,880,000
Supportive Housing Initiative	The Supportive Housing Initiative seeks to ensure that Medicaid members have proper housing that promotes a healthy environment and lifestyle as a social determinant of health. These resources utilize innovative housing program models to provide support services.	$163,212,000
Tobacco Control	The Department through the Bureau of Tobacco Control administers the state's comprehensive Tobacco Control Program to reduce illness, disability, and death related to commercial tobacco use and secondhand smoke exposure, and to alleviate social and economic inequities caused by tobacco use. The program uses an evidence-based, policy-driven, and population-level approach to tobacco control and prevention with a commitment to promote health equity among populations disproportionately impacted by tobacco marketing and use. The Tobacco Control Program's efforts and actions have contributed to record-low youth and adult smoking rates in New York state.	$162,576,000
Total Allowable DSHP-Eligible Expenditures		**$4,323,664,110**
Total DSHP Cap. The state must not claim more than $3,981,442,500 of DSHP.		**$3,981,442,500**

Attachment O
DSHP Claiming Protocol (Reserved)

Attachment P
Monitoring Protocol for Other Policies (Reserved)

Attachment Q
DSHP Sustainability Plan (Reserved)

APPENDIX 12

ADA.gov
U.S. Department of Justice
Civil Rights Division

Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead* v. L.C.

Last updated: February 28, 2020

In the years since the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), the goal of the integration mandate in title II of the Americans with Disabilities Act – to provide individuals with disabilities opportunities to live their lives like individuals without disabilities – has yet to be fully realized. Some state and

local governments have begun providing more integrated community alternatives to individuals in or at risk of segregation in institutions or other segregated settings. Yet many people who could and want to live, work, and receive services in integrated settings are still waiting for the promise of *Olmstead* to be fulfilled.

Guidance & Resources

Read this to get specific guidance about this topic.

For a beginner-level introduction to a topic, view Topics
For information about the legal requirements, visit Law, Regulations & Standards

In 2009, on the tenth anniversary of the Supreme Court's decision in *Olmstead*, President Obama launched "The Year of Community Living" and directed federal agencies to vigorously enforce the civil rights of Americans with disabilities. Since then, the Department of Justice has made enforcement of *Olmstead* a top priority. As we commemorate the 12th anniversary of the *Olmstead* decision, the Department of Justice reaffirms its commitment to vindicate the right of individuals with disabilities to live integrated lives under the ADA and *Olmstead*. To assist individuals in understanding their rights under title II of the ADA and its integration mandate, and to assist state and local governments in complying with the ADA, the Department of Justice has created this technical assistance guide.

The ADA and Its Integration Mandate

In 1990, Congress enacted the landmark Americans with Disabilities Act "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." [1] In passing this groundbreaking law, Congress recognized that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem. [2] For those reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.[3]

As directed by Congress, the Attorney General issued regulations implementing title II, which are based on regulations issued under section 504 of the Rehabilitation Act. [4] The title II regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." [5] The preamble discussion of the "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible . . . ."[6]

In *Olmstead v. L.C.*, 527 U.S. 581 (1999), the Supreme Court held that title II prohibits the unjustified segregation of individuals with disabilities. The Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity. [7] The Supreme Court explained that this holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of

participating in community life." Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.[8]

To comply with the ADA's integration mandate, public entities must reasonably modify their policies, procedures or practices when necessary to avoid discrimination.[9] The obligation to make reasonable modifications may be excused only where the public entity demonstrates that the requested modifications would "fundamentally alter" its service system.[10]

In the years since the passage of the ADA and the Supreme Court's decision in *Olmstead*, the ADA's integration mandate has been applied in a wide variety of contexts and has been the subject of substantial litigation. The Department of Justice has created this technical assistance guide to assist individuals in understanding their rights and public entities in understanding their obligations under the ADA and *Olmstead*. This guide catalogs and explains the positions the Department of Justice has taken in its Olmstead enforcement. It reflects the views of the Department of Justice only. For questions about this guide, you may contact our ADA Information Line, 800-514-0301 (voice), 833-610-1264 (TTY).

Questions and Answers on the ADA's Integration Mandate and *Olmstead* Enforcement

1. What is the most integrated setting under the ADA and *Olmstead*?

A. The "most integrated setting" is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."[11] Integrated settings are those that provide individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities. Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies and with persons of an individual's choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible. Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings. By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.

2. When is the ADA's integration mandate implicated?

A. The ADA's integration mandate is implicated where a public entity administers its programs in a manner that results in unjustified segregation of persons with disabilities. More specifically, a public entity may violate the ADA's integration mandate when it: (1) directly or indirectly operates facilities and or/programs that segregate individuals with disabilities; (2) finances the segregation of individuals with disabilities in private facilities; and/or (3) through its planning, service system design, funding choices, or service implementation practices, promotes or relies upon the segregation of individuals with disabilities in private facilities or programs.[12]

3. Does a violation of the ADA's integration mandate require a showing of facial discrimination?

A. No, in the *Olmstead* context, an individual is not required to prove facial discrimination. In *Olmstead*, the court held that the plaintiffs could make out a case under the integration mandate even if they could not prove "but for" their disability, they would have received the community-based services they sought. It was enough that the state currently provided them services in an institutional setting that was not the most integrated setting appropriate.[13] Additionally, an *Olmstead* claim is distinct from a claim of disparate treatment or disparate impact and accordingly does not require proof of those forms of discrimination.

4. What evidence may an individual rely on to establish that an integrated setting is appropriate?

A. An individual may rely on a variety of forms of evidence to establish that an integrated setting is appropriate. A reasonable, objective assessment by a public entity's treating professional is one, but only one, such avenue. Such assessments must identify individuals' needs and the services and supports necessary for them to succeed in an integrated setting. Professionals involved in the assessments must be knowledgeable about the range of supports and services available in the community. However, the ADA and its regulations do not require an individual to have had a state treating professional make such a determination. People with disabilities can also present their own independent evidence of the appropriateness of an integrated setting, including, for example, that individuals with similar needs are living, working and receiving services in integrated settings with appropriate supports. This evidence may come from their own treatment providers, from community-based organizations that provide services to people with disabilities outside of institutional settings, or from any other relevant source. Limiting the evidence on which *Olmstead* plaintiffs may rely would enable public entities to circumvent their *Olmstead* requirements by

failing to require professionals to make recommendations regarding the ability of individuals to be served in more integrated settings.

5. What factors are relevant in determining whether an individual does not oppose an integrated setting?

A. Individuals must be provided the opportunity to make an informed decision. Individuals who have been institutionalized and segregated have often been repeatedly told that they are not capable of successful community living and have been given very little information, if any, about how they could successfully live in integrated settings. As a result, individuals' and their families' initial response when offered integrated options may be reluctance or hesitancy. Public entities must take affirmative steps to remedy this history of segregation and prejudice in order to ensure that individuals have an opportunity to make an informed choice. Such steps include providing information about the benefits of integrated settings; facilitating visits or other experiences in such settings; and offering opportunities to meet with other individuals with disabilities who are living, working and receiving services in integrated settings, with their families, and with community providers. Public entities also must make reasonable efforts to identify and addresses any concerns or objections raised by the individual or another relevant decision-maker.

6. Do the ADA and *Olmstead* apply to persons at serious risk of institutionalization or segregation?

A. Yes, the ADA and the *Olmstead* decision extend to persons at serious risk of institutionalization or segregation and are not limited to individuals currently in institutional or other segregated settings. Individuals need not wait until the harm of institutionalization or segregation occurs or is imminent. For example, a plaintiff could show sufficient risk of institutionalization to make out an *Olmstead* violation if a public entity's failure to provide community services or its cut to such services will likely

cause a decline in health, safety, or welfare that would lead to the individual's eventual placement in an institution.

7. May the ADA and *Olmstead* require states to provide additional services, or services to additional individuals, than are provided for in their Medicaid programs?

A. A state's obligations under the ADA are independent from the requirements of the Medicaid program.[14] Providing services beyond what a state currently provides under Medicaid may not cause a fundamental alteration, and the ADA may require states to provide those services, under certain circumstances. For example, the fact that a state is permitted to "cap" the number of individuals it serves in a particular waiver program under the Medicaid Act does not exempt the state from serving additional people in the community to comply with the ADA or other laws.[15]

8. Do the ADA and *Olmstead* require a public entity to provide services in the community to persons with disabilities when it would otherwise provide such services in institutions?

A. Yes. Public entities cannot avoid their obligations under the ADA and *Olmstead* by characterizing as a "new service" services that they currently offer only in institutional settings. The ADA regulations make clear that where a public entity operates a program or provides a service, it cannot discriminate against individuals with disabilities in the provision of those services.[16] Once public entities choose to provide certain services, they must do so in a nondiscriminatory fashion.[17]

9. Can budget cuts violate the ADA and *Olmstead*?

A. Yes, budget cuts can violate the ADA and *Olmstead* when significant funding cuts to community services create a risk of institutionalization or segregation. The most obvious example of such a risk is where budget cuts

require the elimination or reduction of community services specifically designed for individuals who would be institutionalized without such services. In making such budget cuts, public entities have a duty to take all reasonable steps to avoid placing individuals at risk of institutionalization. For example, public entities may be required to make exceptions to the service reductions or to provide alternative services to individuals who would be forced into institutions as a result of the cuts. If providing alternative services, public entities must ensure that those services are actually available and that individuals can actually secure them to avoid institutionalization.

10. What is the fundamental alteration defense?

A. A public entity's obligation under *Olmstead* to provide services in the most integrated setting is not unlimited. A public entity may be excused in instances where it can prove that the requested modification would result in a "fundamental alteration" of the public entity's service system. A fundamental alteration requires the public entity to prove "that, in the allocation of available resources, immediate relief for plaintiffs would be inequitable, given the responsibility the State [or local government] has taken for the care and treatment of a large and diverse population of persons with [ ] disabilities."[18] It is the public entity's burden to establish that the requested modification would fundamentally alter its service system.

11. What budgetary resources and costs are relevant to determine if the relief sought would constitute a fundamental alteration?

A. The relevant resources for purposes of evaluating a fundamental alteration defense consist of all money the public entity allots, spends, receives, or could receive if it applied for available federal funding to provide services to persons with disabilities. Similarly, all relevant costs, not simply those funded by the single agency that operates or funds the segregated or integrated setting, must be considered in a fundamental alteration analysis.

Moreover, cost comparisons need not be static or fixed. If the cost of the segregated setting will likely increase, for instance due to maintenance, capital expenses, environmental modifications, addressing substandard care, or providing required services that have been denied, these incremental costs should be incorporated into the calculation. Similarly, if the cost of providing integrated services is likely to decrease over time, for instance due to enhanced independence or decreased support needs, this reduction should be incorporated as well. In determining whether a service would be so expensive as to constitute a fundamental alteration, the fact that there may be transitional costs of converting from segregated to integrated settings can be considered, but it is not determinative. However, if a public entity decides to serve new individuals in segregated settings ("backfilling"), rather than to close or downsize the segregated settings as individuals in the plaintiff class move to integrated settings, the costs associated with that decision should not be included in the fundamental alteration analysis.

12. What is an *Olmstead* Plan?

A. An *Olmstead* plan is a public entity's plan for implementing its obligation to provide individuals with disabilities opportunities to live, work, and be served in integrated settings. A comprehensive, effectively working plan must do more than provide vague assurances of future integrated options or describe the entity's general history of increased funding for community services and decreased institutional populations. Instead, it must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain concrete and reliable commitments to expand integrated opportunities. The plan must have specific and reasonable timeframes and measurable goals for which the public entity may be held accountable, and there must be funding to support the plan, which may come from reallocating existing service dollars. The plan should include commitments for each group of persons who are unnecessarily segregated, such as individuals residing in facilities for individuals with developmental disabilities, psychiatric hospitals, nursing

homes and board and care homes, or individuals spending their days in sheltered workshops or segregated day programs. To be effective, the plan must have demonstrated success in actually moving individuals to integrated settings in accordance with the plan. A public entity cannot rely on its *Olmstead* plan as part of its defense unless it can prove that its plan comprehensively and effectively addresses the needless segregation of the group at issue in the case. Any plan should be evaluated in light of the length of time that has passed since the Supreme Court's decision in *Olmstead*, including a fact-specific inquiry into what the public entity could have accomplished in the past and what it could accomplish in the future.

13. What must a public entity show to establish a fundamental alteration defense based on an *Olmstead* plan?

A. A public entity raising a fundamental alteration defense based on an *Olmstead* plan must show that it has developed a comprehensive, effectively working *Olmstead* plan that meets the standards described above, and that it is implementing the plan. A public entity that cannot show it has and is implementing a working plan will not be able to prove that it is already making sufficient progress in complying with the integration mandate and that the requested relief would so disrupt the implementation of the plan as to cause a fundamental alteration.

14. What is the relevance of budgetary shortages to a fundamental alteration defense?

A. Public entities have the burden to show that immediate relief to the plaintiffs would effect a fundamental alteration of their program. Budgetary shortages are not, in and of themselves, evidence that such relief would constitute a fundamental alteration. Even in times of budgetary constraints, public entities can often reasonably modify their programs by re-allocating funding from expensive segregated settings to cost-effective integrated settings. Whether the public entity has sought additional federal resources available to support the provision of services in integrated settings for the

particular group or individual requesting the modification – such as Medicaid, Money Follows the Person grants, and federal housing vouchers – is also relevant to a budgetary defense.

15. What types of remedies address violations of the ADA's integration mandate?

A. A wide range of remedies may be appropriate to address violations of the ADA and *Olmstead*, depending on the nature of the violations. Remedies typically require the public entity to expand the capacity of community-based alternatives by a specific amount, over a set period of time. Remedies should focus on expanding the most integrated alternatives. For example, in cases involving residential segregation in institutions or large congregate facilities, remedies should provide individuals opportunities to live in their own apartments or family homes, with necessary supports. Remedies should also focus on expanding the services and supports necessary for individuals' successful community tenure. *Olmstead* remedies should include, depending on the population at issue: supported housing, Home and Community Based Services ("HCBS") waivers,[19] crisis services, Assertive Community Treatment ("ACT") teams, case management, respite, personal care services, peer support services, and supported employment. In addition, court orders and settlement agreements have typically required public entities to implement a process to ensure that currently segregated individuals are provided information about the alternatives to which they are entitled under the agreement, given opportunities that will allow them to make informed decisions about their options (such as visiting community placements or programs, speaking with community providers, and meeting with peers and other families), and that transition plans are developed and implemented when individuals choose more integrated settings.

16. Can the ADA's integration mandate be enforced through a private right of action?

A. Yes, private individuals may file a lawsuit for violation of the ADA's integration mandate. A private right of action lies to enforce a regulation that authoritatively construes a statute. The Supreme Court in *Olmstead* clarified that unnecessary institutionalization constitutes "discrimination" under the ADA, consistent with the Department of Justice integration regulation.

17. What is the role of protection and advocacy organizations in enforcing *Olmstead*?

A. By statute, Congress has created an independent protection and advocacy system (P&As) to protect the rights of and advocate for individuals with disabilities.[20] Congress gave P&As certain powers, including the authority to investigate incidents of abuse, neglect and other rights violations; access to individuals, records, and facilities; and the authority to pursue legal, administrative or other remedies on behalf of individuals with disabilities.[21] P&As have played a central role in ensuring that the rights of individuals with disabilities are protected, including individuals' rights under title II's integration mandate. The Department of Justice has supported the standing of P&As to litigate *Olmstead* cases.

18. Can someone file a complaint with the Department of Justice regarding a violation of the ADA and *Olmstead*?

A. Yes, individuals can file complaints about violations of title II and *Olmstead* with the Department of Justice. A title II complaint form is available on-line at archive.ada.gov and can be sent to:

U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue, NW
Washington, DC 20530

Individuals may also call the Department's toll-free ADA Information Line for information about filing a complaint and to order forms and other materials that can assist you in providing information about the violation. The number for the ADA Information Line is (800) 514-0301 (voice) or (833) 610-1264 (TTY).

In addition, individuals may file a complaint about violations of *Olmstead* with the Office for Civil Rights at the U.S. Department of Health and Human Services. Instructions on filing a complaint with OCR are available at http://www.hhs.gov/ocr/civilrights/complaints/index.html

1. 42 U.S.C. § 12101(b)(1). Back to text
2. 42 U.S.C. § 12101(a)(2). Back to text
3. 42 U.S.C. § 12132. Back to text
4. See 42 U.S.C. § 12134(a); 28 C.F.R. § 35.190(a); Executive Order 12250, 45 Fed. Reg. 72995 (1980), reprinted in 42 U.S.C. § 2000d-1. Section 504 of the Rehabilitation Act of 1973 similarly prohibits disability-based discrimination. 29 U.S.C § 794(a) ("No otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . . ."). Claims under the ADA and the Rehabilitation Act are generally treated identically. Back to text
5. 28 C.F.R. § 35.130(d) (the "integration mandate"). Back to text
6. 28 C.F.R. Pt. 35, App. A (2010) (addressing § 35.130). Back to text
7. *Olmstead v. L.C.*, 527 U.S.at 607. Back to text
8. Id. at 600-01. Back to text
9. 28 C.F.R.§ 35.130(b)(7). Back to text
10. Id.; *see* also *Olmstead*, 527 U.S. at 604-07. Back to text

11. 28 C.F.R. pt. 35 app. A (2010). Back to text

12. See 28 C.F.R. § 35.130(b)(1) (prohibiting a public entity from discriminating "directly or through contractual, licensing or other arrangements, on the basis of disability"); § 35.130(b)(2) (prohibiting a public entity from "directly, or through contractual or other arrangements, utilizing criteria or methods of administration" that have the effect of discriminating on the basis of disability"). Back to text

13. *Olmstead*, 527 U.S. at 598; 28 C.F.R. 35.130(d). Back to text

14. *See* CMS, *Olmstead* Update No. 4, at 4 (Jan. 10, 2001), available at https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd011001a.pdf Back to text

15. Id. Back to text

16. 28 C.F.R. § 35.130. Back to text

17. See U.S. Dept. of Justice, ADA Title II Technical Assistance Manual § II-3.6200. Back to text

18. *Olmstead*, 527 U.S. at 604. Back to text

19. HCBS waivers may cover a range of services, including residential supports, supported employment, respite, personal care, skilled nursing, crisis services, assistive technology, supplies and equipment, and environmental modifications. Back to text

20. 42 U.S.C. §§ 15001 et seq. (Developmental Disabilities Assistance and Bill of Rights Act, requiring the establishment of the P&A system to protect and advocate for individuals with developmental disabilities); 42 U.S.C. § 10801 et seq. (The Protection and Advocacy for Individuals with Mental Illness Act, expanding the mission of the P&A to include protecting and advocating for individuals with mental illness) Back to text

21. 42 U.S.C. §§ 10805, 15043. Back to text

The Americans with Disabilities Act authorizes the Department of Justice (the Department) to provide technical assistance to individuals and entities that have rights or responsibilities under the Act. This document provides informal guidance to assist you in understanding the ADA and the Department's regulations.

This guidance document is not intended to be a final agency action, has no legally binding effect, and may be rescinded or modified in the Department's complete discretion, in accordance with applicable laws. The Department's guidance documents, including this guidance, do not establish legally enforceable responsibilities beyond what is required by the terms of the applicable statutes, regulations, or binding judicial precedent.

Originally issued: June 22, 2011

Last updated: February 28, 2020

APPENDIX 13

Report and Recommendations of the Olmstead Cabinet

A Comprehensive Plan for Serving New Yorkers with Disabilities in the Most Integrated Setting

OLMSTEAD
Community Integration for Every New Yorker

Andrew M. Cuomo
Governor

Roger Bearden
Special Counsel for Olmstead

"People with disabilities have the right to receive services and supports in settings that do not segregate them from the community; it is a matter of civil rights."

—Governor Andrew M. Cuomo

REPORT AND RECOMMENDATIONS OF THE OLMSTEAD CABINET

A Comprehensive Plan for Serving People with Disabilities in the Most Integrated Setting

New York State

Andrew M. Cuomo, Governor

October 2013

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Introduction

Under Governor Andrew M. Cuomo, New York is reclaiming its leadership role in serving people with disabilities. In 2011, the Governor directed a landmark redesign of the state's Medicaid program in order to improve care coordination and the delivery of cost-effective, community-based care. The Governor also established the Justice Center for the Protection of People with Special Needs (Justice Center), which provides the strongest protections from abuse and neglect for people with disabilities in the nation.

To further safeguard the rights of people with disabilities, in November 2012, Governor Cuomo issued Executive Order Number 84 to create the Olmstead Development and Implementation Cabinet (Olmstead Cabinet). The Olmstead Cabinet was charged with developing a plan consistent with New York's obligations under the United States Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999) (Olmstead). Olmstead held that the state's services, programs, and activities for people with disabilities must be administered in the most integrated setting appropriate to a person's needs.

To examine New York's compliance with Olmstead, the Olmstead Cabinet employed a broad and inclusive process. The Olmstead Cabinet received public comment through four public forums and through a dedicated page on the Governor's website. The cabinet met with over 160 stakeholder organizations and received over 100 position papers. Hundreds of state agency personnel across a dozen agencies providing services to people with disabilities participated in multiple discussions and provided data regarding New York's service systems for people with disabilities.

The results of the Olmstead Cabinet's work are contained in this report. This report identifies specific actions state agencies responsible for providing services to people with disabilities will take to serve people with disabilities in the most integrated setting. These actions will:

- Assist in transitioning people with disabilities out of segregated settings and into community settings;
- Change the way New York assesses and measures Olmstead performance;
- Enhance the integration of people in their communities; and
- Assure accountability for serving people in the most integrated setting.

Together, the actions described in this report will ensure that New York is a leader in providing services to people with disabilities in the most integrated setting, consistent with their fundamental civil rights.

Report and Recommendations

I. The Olmstead Mandate

The Olmstead decision addressed the rights of two women who had been confined in a Georgia state psychiatric hospital for five and seven years beyond the time at which they had been determined ready for community discharge. The United States Supreme Court held that the failure to provide community placement for these people constituted discrimination under the Americans with Disabilities Act. The court also held that states are required to provide community-based services to people with disabilities when: (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving disability services from the state.[1]

The Olmstead case itself concerned people in a psychiatric hospital. Subsequent cases have addressed developmental centers, board and care homes, and people at-risk of institutional care. Most recently, the Olmstead mandate has been extended to segregated employment services for people with disabilities. Given the breadth and continuing evolution of the Olmstead mandate, in order to develop its specific recommendations, the Olmstead Cabinet sought the views of a broad set of stakeholders regarding the areas in which the cabinet should focus its attention. Through this stakeholder engagement, four areas of focus emerged:

1. The need for strategies to address specific populations in unnecessarily segregated settings, including:
    a. People with intellectual and developmental disabilities in developmental centers, intermediate care facilities (ICFs), and sheltered workshops;
    b. People with serious mental illness in psychiatric centers, nursing homes, adult homes, and sheltered workshops; and
    c. People in nursing homes.
2. The need to increase opportunities for people with disabilities to live integrated lives in the community;
3. The need to develop consistent cross-systems assessments and outcomes measurements regarding how New York meets the needs and choices of people with disabilities in the most integrated setting;
4. The need for strong Olmstead accountability measures.

The following sections of this report discuss each of these areas of focus in turn.

[1] *Olmstead v. L.C.*, 527 U.S. 581. (1999).

II. Transitioning People with Disabilities from Segregated Settings to the Community

In collaboration with state agencies providing services to people with disabilities and a broad set of stakeholders, the Olmstead Cabinet sought to identify specific strategies to assist people with disabilities residing in segregated settings to transition to community-based settings. The specific settings and strategies are described in the sections that follow.

A. People with Intellectual and Developmental Disabilities in Developmental Centers, Intermediate Care Facilities, and Sheltered Workshops

In April 2013, Governor Cuomo announced a comprehensive transformation plan for serving people with intellectual and developmental disabilities in the most integrated setting.[2] The plan addresses the approximately 1,000 people who resided in developmental centers as of April 2013. The Office for People With Developmental Disabilities (OPWDD) closed its West Seneca Developmental Center in May 2011 and the Staten Island Multiple Disabilities Unit in June 2012, with the individuals residing at these facilities moving to community-based residential services. In addition, OPWDD will close the Monroe and Taconic developmental centers by December 2013, and the 155 people residing at those centers will move to community-based residential settings.

The transformation plan includes the closure of four additional developmental centers in the next four years: Oswald D. Heck (by March 2015); Brooklyn (by December 2015); Broome (by March 2016); and Bernard M. Fineson (by March 2017). It is projected that OPWDD will retain capacity for 150 individuals to receive short-term intensive treatment services in the remaining developmental centers. In addition, over the next few months, OPWDD will finalize its timeline for additional community transition opportunities for other people with intellectual and developmental disabilities residing in community-based ICFs and nursing homes.

OPWDD is also changing the nature of its service system by developing consistent, person-centered intake practices through its Front Door initiative, a comprehensive, person-centered needs assessment process with enhanced, person-centered planning, a fuller menu of community-based supports to better meet a person's needs in community-based settings, and quality oversight that examines individual outcomes as well as systems measures.[3]

Under its transformation plan, OPWDD will also be exploring new options for community-based housing and has begun participating in the New York State Money Follows the Person (MFP) demonstration. Within the MFP demonstration, people with intellectual and developmental disabilities will transition from institutional settings (developmental centers, community-based ICFs, and nursing homes) to community-based independent housing, supported housing, or supervised residences of four or fewer unrelated people, as appropriate. With this range of housing options and smaller residential service settings, OPWDD anticipates that the people transitioning from institutional settings will lead more integrated lives.

OPWDD's participation in the MFP demonstration began in April 2013. Over the next four years, OPWDD will assist 875 people with developmental disabilities who currently reside in institutional settings to move to community-based settings. This demonstration will require OPWDD to identify people who wish to move to the community and to work with those people to develop transition plans and identify community-based service options to meet their needs in community settings,

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[2] New York. Office for People With Developmental Disabilities. (April 2013). *Road to Reform: Putting People First*. Retrieved from http://www.opwdd.ny.gov/opwdd_about/commissioners_page/OPWDD_Road_to_Reform_April2013.

[3] Additional information about OPWDD's Front Door imitative is available at http://www.opwdd.ny.gov/welcome-front-door/home.

and to facilitate that transition. OPWDD will utilize peer outreach to identify potential MFP demonstration participants, provide accurate information and referral, and effectively address concerns of participants and family members. Contracted transition coordinators will work closely with OPWDD regional staff to transition MFP demonstration participants to the community through Home and Community-Based Services (HCBS) waiver enrollment.

OPWDD will track all participants' experiences in the MFP demonstration using the Quality of Life Survey to measure the community integration outcomes. This survey will be administered prior to MFP demonstration participants' transition to the community, at 11 months post transition, and at 24 months post transition. This survey measures key integration outcomes for people transitioning from institutional to community-based settings, including living situation, choice and control, access to personal care, respect/dignity, community integration/inclusion, overall life satisfaction, and health status.[4]

OPWDD will also promulgate regulatory amendments to align OPWDD regulations and requirements with the federal Centers for Medicare & Medicaid Services' (CMS) proposed standards for HCBS settings.[5] These requirements, which largely mirror existing OPWDD regulations, will be implemented throughout OPWDD's service delivery system and will further define the characteristics of a community-based setting that must be present wherever HCBS services are delivered. In addition to the regulations, OPWDD will adopt implementation guidelines and integrate these enhanced standards into its oversight activities.

An important goal of the transformation of the service system for people with intellectual and developmental disabilities is implementation of a self-directed approach in which MFP demonstration participants and/or their designated representatives will be given the option of self-directing by employer authority and budget authority or, at the preference of the individual, either employer authority or budget authority. As part of this effort, OPWDD will offer increased education to all stakeholders by providing a standard curriculum on self-direction to at least 1,500 people and their designated representatives per quarter beginning on April 1, 2013. As a result, OPWDD has set a goal of enabling 1,245 new people to self-direct their services by March 31, 2014.

Recognizing the need to build additional community capacity to support people with developmental disabilities and their families in the community, OPWDD is piloting the national Systemic, Therapeutic, Assessment, Respite, and Treatment (START) program model to provide emergency crisis services and limited therapeutic respite services.[6] This program will begin as a pilot in the Finger Lakes and Taconic regions, where OPWDD plans to close its developmental centers in 2013.

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[4] Additional information about the Money Follows the Person Quality of Life Survey can be found at http://apply07.grants.gov/apply/opportunities/instructions/oppCMS-1LI-13-001-cfda93.791-cidCMS-1LI-13-001-013945-instructions.pdf.

[5] State Plan Home and Community Based Services under the Act," Proposed Rulemaking. *Federal Register,* 77:86, (May 3, 2012) p. 26361.

[6] Additional information about the Systemic, Therapeutic, Assessment, Respite, and Treatment program can be found at http://www.centerforstartservices.com/community-resources/newyorkpublic.aspx.

OPWDD is also increasing integrated employment opportunities for people with developmental disabilities. On May 31, 2013, New York provided CMS with a baseline count of the number of enrollees receiving supported employment services and the number of enrollees engaged in competitive employment. As of July 1, 2013, OPWDD no longer permits new admissions to sheltered workshops. By October 1, 2013, New York will increase the number of people with developmental disabilities in competitive employment by no fewer than 250 people. Only integrated, gainful employment at minimum wage or higher will be considered competitive employment. New York submitted a draft plan to CMS for review on October 1, 2013, and will submit a final plan no later than January 1, 2014, on its transformation toward a system that better supports competitive employment for people with developmental disabilities.[7]

B. People with Serious Mental Illness in Psychiatric Centers, Nursing Homes, Adult Homes and Sheltered Workshops

The New York State Office of Mental Health (OMH) is implementing the Olmstead mandate in several ways. First, the development of behavioral health managed care will enhance community integrated health and mental health plans of care. Second, the development of Regional Centers of Excellence (RCE) will reorient OMH's state psychiatric center system to focus on high quality, intensive treatment with shorter lengths of stay and enhanced treatment and support in the community.[8] Third, the implementation of two settlement agreements will assist people in moving from nursing homes and adult homes to integrated community apartments supported by services that focus on rehabilitation, recovery, and community inclusion.

Under Medicaid redesign for managed behavioral health care, New York will create special needs Health and Recovery Plans (HARPs): distinctly qualified, specialized, and integrated managed care programs for people with significant behavioral health needs. Mainstream managed care plans may qualify as HARPs only if they meet rigorous standards or if they partner with a behavioral health organization to meet those standards.[9] HARPs will include plans of care and care coordination that are person centered and will be accountable for both in-plan benefits and non-plan services. HARPs will interface with social service systems and local governmental units to address homelessness, criminal justice, and employment related issues, and with state psychiatric centers and health homes to coordinate care. HARPs will include specialized administration and management appropriate to the populations/services, an enhanced benefit package with specialized medical and social necessity/utilization review approaches for expanded recovery-oriented benefits, integrated health and behavioral health services, additional quality metrics and incentives, enhanced access and network standards, and enhanced care coordination expectations.

To support the extension of outpatient services to people in their homes and communities, OMH will seek federal approval to provide mental health outpatient services outside of facility-based locations. Providing mobile services will increase access and effectiveness of care for people who cannot or will not access facility-based services. More accessible, consistent, and effective treatment is expected to reduce the need for inpatient care, and will instead serve people with psychiatric disabilities in the most integrated setting.

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[7] The workplan is available at: http://www.opwdd.ny.gov/opwdd_services_supports/employment_for_people_with_disabilities/draft-plan-increase-employment-opps.

[8] Additional information about the Regional Centers of Excellence is available at http://www.omh.ny.gov/omhweb/excellence/rce/.

[9] New York. Department of Health. (June 18, 2013). *MRT Behavioral Health Managed Care Update*. (PowerPoint slides). Retrieved from http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-6-18_mc_policy_planning_mtg.ppt.

Complementing its transformation of community-based services, in July 2013, OMH announced its plan to transform New York's inpatient psychiatric hospitals into regional centers of excellence (RCEs).[10] RCEs will be regionally-based networks of inpatient and community-based services, each with a specialized inpatient hospital program located at its center with geographically dispersed community service "hubs" overseeing state-operated, community-based services throughout the region. The RCE plan reduces the number of state psychiatric centers from 24 to 15, eliminating 655 inpatient beds in favor of community services. Over the next year, OMH will pursue a regional planning process to guide the development of its RCEs. This planning process will include the assessment of existing community capacity within its five state regions and recommendations for the development of additional community capacity to prevent unnecessary hospitalization and to transition people currently residing in psychiatric hospitals back to their communities. These recommendations will be prepared by December 2013.

Coupled with its community capacity evaluation, OMH will focus on transitioning long-stay patients currently residing at psychiatric hospitals back into the community. OMH has steadily reduced its inpatient psychiatric population from 43,803 in 1973 to 3,876 in 2012 by creating appropriate community placements and supports. As of July 1, 2013, the total number of non-forensic patients in New York's state psychiatric centers was 2,980, 1,328 of whom have stayed longer than one year. Over the next two years, OMH has established a goal to reduce this number of long-stay patients by 10 percent by transitioning these people to appropriate community housing and services.[11]

In addition to its inpatient psychiatric reforms, in September 2011, New York settled a federal class action lawsuit, *Joseph S. v. Hogan*, concerning people with serious mental illness discharged or at risk of discharge to nursing homes from state-operated psychiatric centers and psychiatric wards of general hospitals. All remedy class members capable of and willing to live in the community will be provided with, or otherwise obtain, community housing and community supports by November 2015. In July 2012, OMH awarded contracts for 200 units of supported housing in order to increase the housing available for qualified people transitioning out of nursing homes. An initial community transition list of remedy class members was developed in December 2012 and will continue to be revised through November 2014. In addition, New York revised its pre-admission screen and resident review process for people with serious mental illness proposed for admission to nursing homes to further prevent unnecessary admissions to these facilities.[12]

New York has also pursued a comprehensive strategy to provide community housing for people with serious mental illness residing in transitional adult homes.[13] In 2012, New York awarded contracts for 1,050 supported housing opportunities for residents of transitional adult homes. In 2012, the Department of Health (DOH) and OMH finalized regulations regarding residents of

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[10] New York. Office of Mental Health. (July 11, 2013). *OMH Regional Centers of Excellence: Today Begins a New Era in New York's Behavioral Health System.* Retrieved from http://www.omh.ny.gov/omhweb/excellence/rce/docs/rceplan.pdf.

[11] Non-forensic patients are those not on the following statuses: felony defendants found incompetent to stand trial (CPL §730); defendants found not responsible for criminal conduct due to mental disease or defect (CPL §330.20); pre-trial detainees in local correctional facilities in need of inpatient care (CL §508); inmates sentenced to state and local correctional facilities in need of inpatient care (CL §402); civil patients transferred to a forensic facility (14NYCRR §57.2); and people committed to sex offender treatment programs within a secure treatment facility (MHL Art. 10).

[12] *Joseph S. v. Hogan.* No. 06-cv-01042, ECF 232 (E.D.N.Y. Sept. 7, 2011).

[13] Transitional adult homes are defined in regulations as adult homes with a certified capacity of 80 beds or more in which 25 percent or more of the resident population are people with serious mental illness. See 18 NYCRR §487.13 for more information.

transitional adult homes to assist in their movement to more integrated settings. These regulations were based on a 2012 OMH clinical advisory, which found that such homes "are not clinically appropriate settings for the significant number of people with serious mental illness who reside in such settings, nor are they conducive to the rehabilitation or recovery of such people."[14]

In July 2013, New York reached a settlement with the plaintiffs in longstanding litigation concerning 23 adult homes in New York City serving people with serious mental illness. Over the next five years, New York will provide integrated supported housing to at least 2,000 adult home residents along with appropriate community-based services and supports. The agreement also will ensure that adult home residents have the information they need to make an informed choice about where to live. As these adult home residents choose to move to supported housing, they will participate in a person-centered, transition planning process.

Since January 2011, OMH has shifted its reliance on sheltered workshops to integrated, competitive employment for people with psychiatric disabilities who desire to work. As of December 31, 2013, all OMH funding of community-based sheltered workshops will be converted to funding of programs that support integrated and competitive employment. Agencies received technical support through New York State Rehabilitation Association and the Medicaid Infrastructure Grant to develop sound business plans to transition individuals served in sheltered workshops into integrated, competitive employment. Local government units played integral roles in developing and reviewing plans that were submitted to OMH for review and approval, and agencies operating sheltered workshops were able to reinvest this sheltered workshop funding into one of several alternatives, including assisted competitive employment, transitional employment program, affirmative business, and transitional business programs.[15]

C. People in Nursing Homes

New York has pursued a number of policies to support community living for people with disabilities residing in, or at risk of placement in, nursing homes. These include the MFP demonstration, the Nursing Home Transition and Diversion Waiver, the Traumatic Brain Injury Waiver, the Long-Term Home Health Care Plan, and the Care at Home I and II waivers. All of these alternatives provide access to community-based supports for people who meet the criteria for nursing home level of care.

Through its Medicaid redesign initiatives, over the next several years, New York will include all Medicaid-eligible nursing home residents in mandatory managed care. The mandatory "care management for all" initiative is well underway for people receiving Medicaid only, as well as for people who are dually-eligible (Medicaid and Medicare), over the age of 21, and who require at least 120 days of community-based care. New populations and benefits are expected to steadily phase in to mainstream managed care and managed long-term care over the next few years.

Building on the care management for all initiative, reforms in the 2012-2013 budget removed the financial incentives that may have encouraged nursing home placement. Previously, nursing home costs were "carved out" of managed care rates and were instead covered by the state. This policy had the potential to encourage managed care plans to pressure high-cost people served in community-based settings to enter nursing homes. Budget reforms will include the full cost of nursing home care in managed care rates, which is expected to encourage these plans to seek lower cost, community-based services.

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[14] L.I. Sederer, MD, memorandum, August 8, 2012, available at http://www.omh.ny.gov/omhweb/advisories/Clinical_Advisory_Adult.pdf.

[15] Definitions of these programs are available at http://www.omh.ny.gov/omhweb/cbr/fy09/section_30.html.

For certain people with significant disabilities, the cost of community-based care will exceed that of nursing home care. For these people, New York is developing financing structures that will permit these people to continue to reside in the community or transition from nursing home to the community, as well as avoid clustering people with significant disabilities in certain plans with preferred benefits. These financing structures will likely include the development of a funding pool to provide supplemental payment to plans serving these people to support their high-cost needs in the community.

To complement these initiatives, DOH is currently exploring mechanisms to enhance existing transition and diversion efforts for people currently residing in nursing homes. DOH will develop and adopt Olmstead performance measures which will be incorporated into its managed care contracts. These measures will evaluate the extent to which plans encourage the transition of people from nursing homes to the community; maintain people in the community; prevent nursing home placement; offer consumer-directed services as the first option for plan enrollees; support the use of assistive technologies; and encourage consumer choice and control.

Additionally, DOH has committed to reduce the long-stay population in nursing homes.[16] As of December 31, 2012, the total number of nursing home residents in New York was 119,987, of which 92,539 have stayed 90 days or more.[17] DOH has set a goal of reducing the long-stay population by 10 percent over the next five years. This target will be coupled with a home and community-based services and housing investment strategy to increase the availability of appropriate community-based housing and services.

[16] Here, long stay is defined as residence in a nursing facility for 90 days or longer, for other than a rehabilitative stay.

[17] Data were derived from the Minimum Data Set 3.0 and include all payment sources. Data include continuing care retirement communities and pediatric facilities, but excludes transitional care Units and four non-Medicaid facilities.

III. Assessment and Outcomes Strategies to Advance Community Integration

In addition to identifying strategies to transition people with disabilities from segregated to community-based settings, the Olmstead Cabinet examined the methods by which the state agencies providing services to people with disabilities understand the needs and choices of the people they serve and how those agencies measure whether those needs and choices are being met in the most integrated setting. The Olmstead Cabinet found inconsistencies in these outcome measures and recommends that state agencies providing services to people with disabilities develop or improve their assessment instruments and processes and Olmstead outcomes measures.

Over the past several years, New York has increasingly standardized its assessments of needs and choice for people with disabilities within its service systems. DOH consolidated eight separate assessment instruments previously used in its home care programs into a single instrument, called the Uniform Assessment System-New York (UAS-NY).[18] OPWDD is developing the Coordinated Assessment System-New York (CAS-NY) for all people served within its service system.[19] Significantly, the CAS-NY shares a common core of clinical items with the UAS-NY, which will permit OPWDD and DOH to assure no-wrong-door access to services and programs administered by these two agencies.

Building upon this initiative, OMH will develop an assessment for its community-based mental health system that shares a common core with both the UAS-NY and CAS-NY. OMH will then explore extending this assessment tool to its inpatient psychiatric hospitals.

Similarly, the State Office for the Aging (SOFA) will revise its Comprehensive Assessment for Aging Network Community Based Long Term Care Services (COMPASS) tool to share a common core with the UAS-NY, CAS-NY, and OMH's revised assessment tool. Currently, while the people and families served by SOFA programs are at high risk of spending down to Medicaid eligibility levels, SOFA's current assessment is not interoperable with the UAS-NY and the Minimum Data Set 3.0, used to assess residents of nursing homes. As a result, opportunities for strategic investment in non-Medicaid services to avoid institutionalization may not be readily identified. The development of consistent, cross-systems core assessments of the service needs and choices of people with disabilities of all ages will address this deficiency. Further, technological interfaces between SOFA and DOH data systems will help facilitate meeting cross-systems needs of people and enhance the ability to follow an individual through different systems and determine their progress in meeting their care plans, goals, and objectives.

The process for conducting assessments will also change. To enhance person-centered planning, New York will implement the Community First Choice Option (CFCO) as an amendment to its Medicaid State Plan. The assessment process will be expected to assess for "community first" service options as the default mechanism, so that every person with a disability is offered services in the most integrated setting and only receives services in a more restrictive setting when necessary. Under CFCO, New York will examine and revise existing assessment processes to ensure that service plans will reflect the services and supports important to the individual, identified through an assessment of functional need and preferences for the delivery of such services and

[18] For more information on the Uniform Assessment System-New York, see http://www.health.ny.gov/health_care/medicaid/redesign/uniform_assessment_system/.

[19] For more information on the Coordinated Assessment System-New York, see http://www.opwdd.ny.gov/people_first_waiver/coordinated_assessment_system/.

supports. This revised assessment process will also seek to minimize conflicts of interest by requiring the assessments be conducted independent of the service delivery system.

Building upon interoperable assessment tools and processes, the agencies providing services to people with disabilities will examine and revise their current outcome measures to incorporate Olmstead measures. To achieve community integration for people with disabilities, New York's service systems must measure whether these services maximize the opportunity for people with disabilities to lead integrated lives. These measures should include whether people with disabilities have control over their own day, whether they control where and how they live, whether they have the opportunity to be employed in non-segregated workplaces for a competitive wage, and whether they have the opportunity to make informed choices about services and supports.

Through design teams and workgroups associated with the People First Waiver, OPWDD explored the best practices for measuring the outcomes that are most important to people with developmental disabilities. After this review, OPWDD selected the Council on Quality and Leadership's Personal Outcome Measures (CQL POMs).[20] The 21 measures of the CQL POMs identify the areas of greatest importance to a person receiving supports and the support areas in which improvements may be needed.[21] OPWDD will incorporate the CQL POMs into the new managed care infrastructure for the developmental disabilities service system.

As part of the implementation of Medicaid managed care, DOH, OMH, OPWDD, and the Office of Alcoholism and Substance Abuse Services (OASAS) are establishing common quality measures across all managed care plan types. Similar to the CQL POMs, these measures will include whether people with disabilities have control over their own day, whether they control where and how they live, whether they have the opportunity to be employed in integrated workplaces for a competitive wage, and whether they have the opportunity to make informed choices about services and supports. These measures will be developed in time for the planned June 2014 implementation of the behavioral health managed care initiative.

In addition, state agencies will enhance the comprehensiveness of their assessment tools. For people with disabilities, true community integration involves the ability to access integrated housing, employment, transportation, and support services. In revising their assessment tools, state agencies will jointly identify relevant items that include these domains and incorporate these items into their assessment tools.

Reforms to New York's assessment of needs and choice and Olmstead outcomes measurement will be sustained by investments made under the federal Balancing Incentive Program (BIP).[22] Participation in the BIP will reinforce New York's ongoing efforts to improve access to home and community based long-term care services for those with physical, behavioral health, and/or

[20] Additional information about the Council on Quality and Leadership's Personal Outcome Measures is available at http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/documents/POMs_fact_Sheet_clean.

[21] In addition to personal outcomes, the CQL POMs measure community integration outcomes, such as whether the person is connected to natural support networks, has intimate relationships and friends, chooses where and with whom they live, chooses where they work, lives in integrated environments, interacts with other members of the community, performs different social roles, chooses services, chooses and realizes personal goals, and participates in the life of the community.

[22] New York received an award letter from CMS on March 15, 2013, to participate in the federal Balancing Incentive Program authorized under the Affordable Care Act. For more information about this program, see http://www.health.ny.gov/health_care/medicaid/redesign/balancing_incentive_program.htm.

intellectual and developmental disabilities throughout the state. Through improved access to information and assistance, people with disabilities will be able to make informed choices regarding services, settings, and related issues. To achieve these goals, New York will implement the three structural changes required under BIP. Specifically, New York will enhance the existing New York Connects network to assure a no wrong door/single point of entry for long-term care services and supports, implement a standardized assessment instrument, and assure conflict-free case management services.[23,24]

[23] New York Connects is currently operational in 54 counties and serves as an information and assistance system for long term care services. Additional information about New York Connects is available at www.nyconnects.ny.gov/.

[24] Conflict-free case management is defined by the Balancing Incentive Program as eligibility determination independent of service provision; case managers and evaluators not related to service recipients; robust monitoring and oversight; accessible grievance process; measurement of consumer satisfaction; and meaningful stakeholder engagement. For more information, see http://www.balancingincentiveprogram.org/resources/what-design-elements-does-conflict-free-case-management-system-include.

IV. Supporting Community Integration for People with Disabilities

The Olmstead mandate addresses not only the movement of people with disabilities from segregated to community-based settings, but also the ability of those people to lead integrated lives. Therefore, the Olmstead Cabinet's review sought to identify how New York can further support the integration of people with disabilities in their communities and worked with state agencies to develop policies that would improve community integration.

A. Housing Services

New Yorkers with disabilities need affordable, accessible housing to lead integrated lives. New York has long been a leader in the development of a continuum of housing options for people with disabilities, which include congregate and scattered-site supportive housing, tenant-based rental assistance that enables people with disabilities to lease housing in integrated developments, and apartments specifically set aside for people with various disabilities in mainstream, multi-family housing developments. New York invests over $900 million annually in supportive housing initiatives, and in the past two years, New York has invested an additional $161 million in supportive housing as part of Medicaid redesign.

The Medicaid Redesign Team Affordable Housing Work Group is a cross-agency body composed of representatives from multiple state agencies administering and/or funding supportive housing programs, including OMH, OPWDD, OASAS, DOH, Homes and Community Renewal (HCR), and the Office of Temporary and Disability Assistance (OTDA).[25] This work group has achieved $161 million in supportive housing investments over the last two years for high-cost Medicaid recipients. The work group will reconvene in October 2013 to consider further collaborations to increase the number of available and affordable housing options and community supports to increase the availability of integrated housing.

HCR facilitates the availability of community-based supportive housing for people with disabilities through early decision, scoring, and financing incentives for multi-family housing projects. Housing projects may be jointly funded by HCR and a state human service agency, such as OPWDD, OMH, or OASAS. In 2013 (as in past years) early decision incentives are available for multi-family, supportive housing projects that set aside a percentage of units for low-income veterans with special needs and people with intellectual and developmental disabilities. Project developers must also show that they have entered into agreements with human service providers to operate and fund community-based support services. HCR also awards developers applying for New York State low-income housing tax credits additional points in its scoring system for projects which reserve a percentage of units for people with mobility and sensory impairments, and for those that give preference in tenant selection for people with special needs. Additional tax credits, tax-exempt bond financing, and funding in excess of usual program limits are also available for multi-family housing projects with units set aside for special needs populations, depending on ownership and financing circumstances. Beginning in its 2013 annual funding round, HCR will examine new project applications to assess whether new developments are consistent with Olmstead principles.[26]

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[25] For more information about the Medicaid Redesign Team Affordable Housing Work Group, see http://www.health.ny.gov/health_care/medicaid/redesign/affordable_housing_workgroup.htm.

[26] For more information on the Homes and Community Renewal Annual Funding Round RFP, see http://www.nyshcr.org/Funding/UnifiedFundingMaterials/2013/RFP_MultiFamilyPrograms.pdf.

As part of its monitoring of completed projects, HCR verifies that project units set aside for people with disabilities are occupied by the special needs population intended, as provided for in the developer's regulatory agreement and affirmative marketing plan. In instances where a service provider is unable to provide qualified applicants or has discontinued operations, HCR requires that an acceptable replacement provider be identified and may allow a different special needs population to be targeted.

OTDA engages in a variety of housing initiatives to support the state's implementation of its Olmstead Plan. The agency's Bureau of Housing and Support Services (BHSS) administers both capital and housing programs that are focused on providing supportive housing for homeless people with disabilities and their families in the least restrictive environment possible. OTDA's Homeless Housing and Assistance Program (HHAP), created in 1983, was the first state-funded program in the country to develop supportive housing units for homeless people with disabilities and their families. Among those for whom such housing is provided are homeless people with serious and persistent mental illness, including those with co-occurring substance abuse disorders; people living with HIV/AIDS; people with cognitive impairments such as those caused by traumatic brain injury; and people with other mental and/or physical disabilities. In addition, OTDA's New York State Supportive Housing Program (NYSHHP) provides funding for housing retention services and other supports for formerly homeless people with disabilities who are living in supportive housing programs throughout the state. Many of these supportive housing programs are located in "mixed use" apartment buildings which house people with disabilities along with other community members. Finally, OTDA's Solutions to End Homelessness Program (STEHP) contracts with local not-for-profit agencies to provide eviction prevention services to prevent people at risk of homelessness, including those with disabilities, from losing their housing. STEHP also provides short-term rental assistance and other supports to homeless individuals, including those with disabilities and their families in order to obtain housing available in the general rental market. All of OTDA's housing efforts are aimed at assisting homeless people, including those with disabilities, to obtain and retain housing of their own choosing within the community.

In addition to these programs and incentives, the Olmstead Cabinet examined opportunities for expansion of integrated housing models that will support people with disabilities leaving institutions or at serious risk of institutional care. The Frank Melville Supportive Housing Investment Act of 2010 authorized Section 811 Project Rental Assistance (PRA), specifically designed to support Olmstead implementation efforts by funding developments and subsidizing rental housing with the availability of supportive services for very low income people with disabilities.[27] State-level housing (i.e., HCR) and health and human services agencies (e.g., OPWDD, OMH, DOH) partner to meet the housing and support needs of the target population. The health care agency develops a policy for referrals, tenant selection, and service delivery to ensure that this highly-integrated housing is targeted to a population most in need. Through an interagency partnership, New York will develop and submit an application for PRA when the request for proposals (RFP) is released. Subject to the RFP's guidance, this application will target low income people with disabilities transitioning from institutions or at serious risk of institutional placement.

Additionally, New York has expanded the information available to people with disabilities through the www.NYHousingSearch.gov website. HCR maintains this website as a free service to list and find affordable, accessible housing in New York. To expand the listings of affordable housing, HCR requires that owners and managers of multi-family projects developed since 2006 list all adaptable and adapted apartments, as well all special needs/supportive services apartments. Further, HCR requires developers of new multi-family projects to list all units adapted or set aside for people with

[27] For more information about Section 811 Project Rental Assistance, see http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/mfh/progdesc/disab811.

disabilities when advertising new units or accepting tenant applications.

B. Employment Services

The continued strengthening of New York's economic development strategies will help to assure an adequate supply and breadth of jobs available to people with disabilities. Certain reforms implemented under Governor Cuomo's Spending and Government Efficiency (SAGE) Commission have aligned workforce development programs more closely with the New York's economic development efforts. The Department of Labor (DOL) will build upon these reforms for people with disabilities by coordinating disability workforce strategies and assuring that these initiatives are aligned with New York's economic development strategies, such as Regional Economic Development Council priorities.[28]

DOL will coordinate with state agencies serving people with disabilities (e.g., OMH, OPWDD, OASAS, State Education Department's Adult Career Continuing Education Services – Vocational Rehabilitation (ACCES-VR), and New York State Commission for the Blind (NYSCB)), to better align DOL's disability workforce strategies with the vocational rehabilitation and employment programs administered by those agencies. DOL will increase coordination of disability workforce initiatives by establishing a stronger linkage between disability resource coordination (DRC) activities at One-Stop Career Centers and ACCES-VR. Specifically, DOL regional business services teams, responsible for coordinating One-Stop Career Center business services with regional business strategies and regional labor market information, will include ACCES-VR services in its coordination activities.[29] Further, DOL will use disability resource coordinators, established under a federal Disability Employment Initiative pilot program, to provide specialized services designed to increase employment opportunities for people with disabilities through skills upgrading (e.g., on-the-job training, obtaining industry-recognized credentials, entrepreneurial training, and customized training) and community partnerships with agencies that support people in employment, life coaching, and asset development.[30]

This increased employment coordination will build upon the comprehensive employment supports coordination and data system called the New York Employment Services System (NYESS).[31] NYESS provides New Yorkers of all abilities with a central point of access to all employment-related services and supports offered by DOL, ACCES-VR, NYSCB, OMH, OPWDD, OASAS, and SOFA. This system connects to the New York State Job Bank, where approximately 90,000 job openings are currently listed each month by employers. Increasing the number of providers and customers in NYESS will allow for comprehensive data analysis of the talent pipeline of people with disabilities. This analysis will include the educational attainment, employment status, and career sectors in which people with disabilities are represented, which will better enable New York to strategically implement effective policy around employment services for people with disabilities.

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[28] For more information about New York's 10 Regional Economic Development Council priorities, see http://regionalcouncils.ny.gov/.

[29] For more information about the Department of Labor regional business services teams, see http://www.labor.ny.gov/workforcenypartners/ta/ta10-12.pdf.

[30] For more information about the federally-funded Disability Employment Initiative in New York, see http://www.labor.ny.gov/workforcenypartners/dpn_dei.shtm.

[31] For more information about the New York Employment Services System, see http://www.nyess.ny.gov/.

DOL and other partner staff will continue to engage Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) beneficiaries with benefits advisement and work incentive counseling in an effort to increase the assignment of tickets to the state under the Social Security Administration's (SSA) Ticket to Work (TTW) program. For people eligible for the TTW program, DOL, ACCES-VR, OPWDD, OMH, and NYSCB will develop a cross-systems assessment protocol to assess each individual's vocational rehabilitation and employment service needs. This protocol will assure that an individual's ticket assignment options are based on individual needs to achieve competitive employment, consistent with the unique strengths, abilities, interests, and informed choice of the individual. This cooperative approach will provide a broad range of employment and career services options for people with disabilities.

Engaging community employers around the benefits of hiring people with disabilities would also improve the opportunities for competitive, integrated employment. Efforts such as the "Think Beyond the Label" advertising campaign help to raise awareness among employers across the state about the benefits of hiring people with disabilities. New York will market various tax credits and incentives, such as the Workers with Disabilities Tax Credit and the Work Opportunity Tax Credit to encourage community employers to hire people with disabilities.

C. Transportation Services

In addition to New York's housing and employment services, transportation services are also fundamental to community living for people with disabilities. New York has conducted a variety of self-evaluation exercises to review its disability transportation strategies (e.g., assessments conducted by the Department of Transportation, Most Integrated Setting Coordinating Council (MISCC), and New York Makes Work Pay[32,33,34]) in recent years. These reports, and the Olmstead Cabinet's review, show a continued need for coordination of disability transportation services.

A federal executive order was issued in 2004 supporting coordinated transportation planning.[35] A cornerstone of such efforts is the establishment of mobility management, a strategic approach to service coordination and customer service to enhance the ease of use and accessibility of transportation networks. Mobility management meets the unique set of transportation needs in each local area by acting as a functional point of coordination for each community's public and private human services organizations and public transportation providers. Mobility management forms and sustains effective partnerships among transportation providers in a community by providing a single, localized source for coordinating and dispatching the full range of available transportation resources to customers. The partnerships formed by mobility management are meant to increase the available travel services for riders and create resource and service efficiencies for transportation providers.

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[32] For more information about the Department of Transportation review of transportation services, see https://www.dot.ny.gov/programs/adamanagement/ada-management-plan/appendix.

[33] For more information about the Most Integrated Setting Coordinating Council review of transportation services, see http://www.opwdd.ny.gov/node/784.

[34] To access the New York Makes Work Pay report, see http://www.nymakesworkpay.org/docs/Transportation_PWDs_NYS_032010.pdf.

[35] Exec. Order No. 13330. 69 FR 9185-9187. (2004). Retrieved from http://www.gpo.gov/fdsys/pkg/FR-2004-02-26/pdf/04-4451.pdf.

Under Medicaid redesign, New York implemented a transportation management system, through state-managed contracts, to improve coordination and cost effectiveness for non-emergency Medicaid transportation.[36] Non-emergency Medicaid transportation is only available to access medical care covered by Medicaid. Therefore, there remains a need for enhanced coordination of transportation resources to assure the availability of services for people with disabilities who need transportation to work or engage in other non-medical activities.

Prior to Medicaid redesign, a number of local transportation providers had begun to implement mobility management programs for both non-emergency Medicaid and non-medical transportation. New York will review the impacts of Medicaid redesign on these local mobility management efforts. This review will evaluate the cost effectiveness and availability of non-emergency Medicaid and non-medical transportation resources for people with disabilities. Based upon this analysis, New York will consider a pilot program to expand the existing Medicaid transportation management system to non-medical trips.

D. Children's Services

Children with disabilities in residential care and those at risk of placement require strategies capable of specifically addressing their personal, familial, and educational resource needs. New York has long recognized the unique relationships between children and families, the roles of multiple agencies in addressing children's needs, and the need to plan for transitions from childhood to adulthood.

The decision that a student needs out-of-home placement in a residential school must be based on the Committee on Special Education's determination that there is no appropriate alternative available to meet the educational needs of the student. New York adopted Chapter 600 of the Laws of 1994, which was intended to discourage unnecessary out-of-home placements by increasing the connection between families and children at risk of placement with local support services.[37] Recognizing that a single system cannot meet all the needs of children with disabilities and their families, CSE membership includes, with the consent of the parent (or student if age 18 or older), representatives from local social service departments, state agencies (e.g., OMH, OPWDD), and local school districts. CSEs provide families with information about in-home and community support services available as alternatives to out-of-home placement to address the unique needs of the child and family. CSEs also consider post-secondary goals and transition services for older students. In 2011, the State Department of Education strengthened its review of proposed out-of-state educational placements to assure adherence with the law.[38]

The Coordinated Children's Services Initiative (CCSI) is another mechanism for serving children with disabilities in the most integrated setting. This initiative began in the 1990s and is currently operated by the Council on Children and Families. CCSI is an approach to developing individual/family-, county- and state-level mechanisms to identify individual and family needs, coordinate multiple service systems, address barriers to coordinated service delivery, and assure that funding is available to prevent out-of-home placement of children with disabilities.[39]

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[36] For more information about the Medicaid transportation management initiative, see http://www.health.ny.gov/funding/rfp/inactive/1103250338/.

[37] For more information about the changes to New York's Social Services and Education Law as a result of Chapter 600, see http://www.p12.nysed.gov/specialed/publications/policy/chap600.pdf.

[38] For more information about the updated procedures, forms, and policy regarding a school district's responsibilities under Chapter 600 of the Laws of 1994, see http://www.p12.nysed.gov/specialed/publications/outofstateplacementsEIP.htm.

[39] For more information about the Coordinated Children's Services Initiative, see http://ccf.ny.gov/CCSI/index.cfm.

Recent Medicaid redesign initiatives have further sought to coordinate the unique service needs of children with disabilities and their families to prevent out-of-home placements. In 2011, the Medicaid Redesign Team Children's Work Group was created to redesign behavioral health services for children. This work group focused on early identification of trauma and behavioral health needs via primary care, collaborative, multi-system care models of treatment, specialty care treatment capacity (including clinical and wrap-around services), family engagement, cross-systems care coordination, and funding and administrative alignment.

The children's work group determined that the Medicaid Children's Behavioral Health Care system, currently funded through Medicaid fee-for-service, should be transitioned to Medicaid managed care. Under Medicaid managed care, physical health, behavioral health, and community support services will be coordinated through person- and family-centered care plans. Olmstead outcome measures will be incorporated into managed care plans, and will seek to ascertain whether services for children maximize the opportunity for children with disabilities to lead integrated lives. The transition to this reformed children's managed care system is planned for January 2016.

E. Aging Services

In addition to the Medicaid redesign initiatives to assist people with disabilities residing or at risk of placement in nursing homes, the Olmstead Cabinet reviewed non-Medicaid services for older adults that may delay or prevent institutionalization, hospital utilization, and Medicaid spend down. Federal, state, and local funds sustain a variety of non-medical, long-term services and supports targeted at older people at risk of nursing home placement and Medicaid spend-down, with the goal of avoiding higher levels of care and public financing of such care. In particular, the Expanded In-home Services for the Elderly Program provides case management and non-medical, in-home and ancillary services for people who need assistance with activities of daily living and instrumental activities of daily living.[40,41,42] Other services, such as congregate and home delivered meals, transportation, and caregiver services, supported through federal, state, and local funds, also assist older New Yorkers to remain in their homes and communities.

As previously noted, SOFA will revise its COMPASS tool to share a common core with the UAS-NY, CAS-NY, and OMH's revised assessment. This revision will help identify opportunities for strategic investment in non-Medicaid services to avoid institutionalization. Further, technological interfaces between SOFA and DOH data systems will help meet cross-systems needs of people with disabilities and enhance the ability to follow a person through different service systems and determine his/her progress in meeting care plan goals and objectives.

SOFA also administers New York Connects, the state's federally-designated Aging and Disability Resource Center to serve as a no wrong door/single point of entry to long-term supports and services for people of all ages with disabilities.[43] Using BIP funds, New York Connects will be strengthened to provide better information to people with disabilities and older adults about both private and public community-based services and supports available to meet their needs. This resource center will also provide options counseling to assist with decision making. These services

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[40] For more information about the Expanded In-home Services for the Elderly Program, see http://www.health.ny.gov/health_care/medicaid/program/longterm/expand.htm.

[41] Self-care activities are activities that a person tends to do every day, including feeding, bathing, toileting, dressing, and grooming.

[42] In addition to activities of daily living, a person must be able to perform instrumental activities in order to live independently, including shopping, transportation, and housekeeping.

[43] For more information about New York Connects, see http://www.nyconnects.ny.gov/nyprovider/consumer/indexNY.do.

are expected to enhance a person's ability to receive the right service at the right time in the right setting for the right cost.

Further, SOFA will strengthen its Long-Term Care Ombudsman Program to assist residents of nursing homes and adult homes to transition to community-based services and supports.[44] Ombudsmen currently help residents understand and exercise their rights in facilities and work to resolve problems between residents and facility staff/administrators. Ombudsmen will be trained to assist nursing home and adult home residents to exercise their rights to community placement and to facilitate linkages to community resources, consistent with proposed federal guidelines regarding long-term care ombudsmen.[45]

F. Criminal Justice

The Olmstead Cabinet examined two criminal justice issues concerning people with disabilities and the Olmstead mandate. First, the cabinet sought to assure that people with disabilities who leave correctional facilities are able to access needed community-based services. Second, the cabinet reviewed current state policies to assure that people with disabilities are not unnecessarily incarcerated for minor offenses that are a result of their disability.

Under Medicaid redesign, New York has enhanced its ability to voluntarily engage people with significant behavioral health needs in services and provide strong follow-up upon discharge from institutional settings. For the limited number of people who do not voluntarily access services, the New York Secure Ammunition and Firearms Enforcement (SAFE) Act strengthened assisted outpatient treatment.[46]

OMH works closely with the Department of Corrections and Community Supervision to implement robust statewide policies for screening people in prisons for mental illness, provide mental health services in prisons, and facilitate reentry from prisons to the community. OMH also offers in-reach services to link prisoners with community-based services and employs pre-release coordinators in prisons throughout the state. These coordinators link mentally ill prisoners with appropriate services in the community and assist, where appropriate, in applying for entitlements such as Medicaid and SSI/SSDI.[47]

County-based services for mentally ill jail inmates are supplemented with state funding through the Medication Grant Program to pay for psychotropic medications for released inmates while their Medicaid application is pending. In addition, OMH provides over $4 million annually to support transition programming in local jails.

The majority of services to divert people with disabilities from the criminal justice system and transition mentally ill inmates back into the community, however, are administered at a local level.

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[44] For more information about the Long-Term Care Ombudsman program, see http://www.ltcombudsman.ny.gov/.

[45] "State Long-Term Care Ombudsman Program, Proposed Rules." *Federal Register*, 78:117. (June 18, 2013) p. 36449-36469. Retrieved from http://www.gpo.gov/fdsys/pkg/FR-2013-06-18/html/2013-14325.htm.

[46] Information about the impact of the New York Secure Ammunition and Firearms Enforcement Act on mental health services can be found at http://www.omh.ny.gov/omhweb/safe_act/.

[47] Recipients of services at OMH forensic facilities are almost always discharged to an OMH civil psychiatric center prior to transitioning back to the community. Residents in OMH secure treatment facilities are transitioned back into the community through the Strict and Intensive Supervision and Treatment program, established by MHL Art. 10.

These local services include law enforcement, courts, jails, and community supervision. Examples of pre-arrest diversion programs that exist across the state are crisis intervention teams, emotionally disturbed people response teams, and mobile crisis teams. In addition, there are currently 28 mental health courts throughout the state, and the Mental Health Connections program shares current mental health court resources with counties that do not have an established mental health court.

A number of recent reforms will further support the diversion of people with disabilities from the criminal justice system and facilitate reentry from the criminal justice system. Notably, OMH has significantly increased the number of supported housing units for parolees with serious mental illness. It also has partnered with the Center for Urban Community Services (CUCS) to develop the Reentry Coordination System in New York City, which operates as a forensic single point of entry for services, including housing, intensive case management, assertive community treatment, and outpatient clinic services. In addition, OMH has collaborated with the New York City Department of Health and Mental Hygiene and with CUCS to establish the Academy for Justice-Informed Practice to cross-train mental health and criminal justice practitioners on best practices for working with justice-involved, mental health service recipients.[48]

The Division of Criminal Justice Services (DCJS) oversees the operation of 19 county reentry task forces and provides $3 million annually through performance-based contracts with localities to support the reentry of people returning from state prisons. DCJS also provides specialized training to police officers to address the needs of people with mental illness.

DCJS was recently awarded a grant from the Bureau of Justice Assistance to provide training and technical assistance to up to 10 localities with high crime rates and high per member per month Medicaid spending to address the needs of people with serious mental illness in the criminal justice system and coordinate with community-based treatment and supports. Using the Sequential Intercept Model, DCJS will work collaboratively with OMH to assist localities in conducting countywide mapping of mental health and criminal justice resources for planning purposes.[49] DCJS and OMH also will provide training and technical assistance to identify local service gaps and develop strategies to address unmet need at each interception point. These strategies will help counties address the needs of people with serious mental illness involved in the criminal justice system and connect them to community-based treatment and supports, which is expected to decrease crime rates and the burden on local jails while improving mental health outcomes for the people served. Initial outcome measures for this initiative will seek to identify probationers screened for mental illness, probationers supervised through the joint probation/mental health case management model, probationers with mental illness successfully completing probation supervision, the number of jail admissions screened for mental illness, and the number of police officers completing crisis intervention training.

G. Legal Reform

To promote the full integration of people with disabilities in the community, the Olmstead Cabinet examined legal and regulatory barriers that impact the ability of people with disabilities to achieve

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[48] For more information about the Center for Urban Community Services and the Academy for Justice-Informed Practice, see http://www.cucs.org/training-and-consulting/training/nyc-training-program.

[49] The Sequential Intercept Model, developed by SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, identifies five key points within the criminal justice system where people with serious mental illness can be intercepted and diverted to community-based alternatives: (1) law enforcement, (2) initial detention/initial court hearings, (3) jails/courts, (4) re-entry, and (5) community corrections. For more information, see http://gainscenter.samhsa.gov/pdfs/integrating/GAINS_Sequential_Intercept.pdf.

community integration. The Olmstead Cabinet identified two issues requiring legal reform: access to health-related task assistance in community settings and guardianship laws for people with intellectual and developmental disabilities.

A barrier to community integration for many people with disabilities is their ability to access community-based assistance with health-related tasks, including medication management, medication administration, and other home health treatments. Recognizing these barriers, current law authorizes people with disabilities served by certain programs to receive assistance with these tasks from non-nursing personnel. People receiving home care services under the Consumer Directed Personal Assistance Program (CDPAP) may direct another individual to provide them with health-related task assistance.[50] Additionally, people with intellectual and developmental disabilities residing in OPWDD certified residences can utilized trained and certified direct care staff for medication, tube feedings, and insulin administration, as well as for other health-related tasks under the supervision of a registered professional nurse.[51]

However, for people with disabilities not served by these programs, facility-based care is often the only option for receiving needed assistance with these health-related tasks. For example, while a person with a developmental disability residing in a group home certified by OPWDD may receive assistance with medication administration by an unlicensed direct care staff member, the same person could not receive this level of assistance in an independent apartment. Likewise, people with physical disabilities enrolled in the CDPAP program can receive the assistance of an unlicensed aide in their own homes if they or a designee assumes full responsibility for hiring, training, supervising, terminating the employment of people providing the services, but could not make use of an unlicensed aide if they wish to direct another in the provision of health-related task assistance, but do not wish to assume all responsibilities associated with the CDPAP program. Similar barriers exist for other people with disabilities who need assistance with health-related tasks to live successfully in the community.

In order to fully support community integration for people with disabilities, current restrictions on community-based health-related task assistance require reform. A broader application of the current self-direction exemption of the Nurse Practice Act for CDPAP enrollees should be explored to cover all people with disabilities who are capable of directing others to provide health-related task assistance. For people not capable of directing others to provide this assistance, a broader application of the exemption within the Nurse Practice Act for certified settings, as currently implemented by OPWDD, should be explored to cover all integrated, community-based housing for people with disabilities.

The Olmstead Cabinet also recommends reform to law governing guardianship over people with developmental disabilities. Community integration includes the ability of people with disabilities to make their own choices to the maximum extent possible. Guardianship removes the legal decision-making authority of an individual with a disability and should, consistent with Olmstead, only be imposed if necessary and in the least restrictive manner. New York maintains two separate systems of guardianship for people with disabilities. Article 17A of the Surrogate Court's Procedure Act, adopted in 1969, applies to people with developmental disabilities. Article 81 of Mental Hygiene Law, adopted in 1987, applies to all other people with disabilities.

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[50] For more information about Consumer Directed Personal Assistance Program requirements, see http://www.health.ny.gov/health_care/medicaid/program/longterm/cdpap.htm.

[51] To access the Office for Mental Retardation and Developmental Disabilities and State Education Department's joint Memorandum of Understanding #2003-01 for registered nursing supervision of unlicensed direct care staff in certified residential facilities, see http://www.op.nysed.gov/prof/nurse/nurse-omrddadminmemo2003-1.htm.

Under Article 17A, the basis for appointing a guardian is diagnosis driven and is not based upon the functional capacity of the person with disability. A hearing is not required, but if a hearing is held, Article 17A does not require the presence of the person for whom the guardianship is sought. Additionally, Article 17A does not limit guardianship rights to the individual's specific incapacities, which is inconsistent with the least-restrictive philosophy of Olmstead. Once guardianship is granted, Article 17A instructs the guardian to make decisions based upon the "best interests" of the person with a disability and does not require the guardian to examine the choice and preference of the person with a disability.

In contrast, Article 81 imposes guardianship based upon a functional analysis of a person's disability, requires a hearing, requires the presence of the person over whom guardianship is sought at the hearing, requires guardianship to be tailored to the person's functional incapacities, and requires the guardian to consider the person's choice and preference in making decisions. The Olmstead Cabinet recommends that Article 17A be modernized in light of the Olmstead mandate to mirror the more recent Article 81 with respect to appointment, hearings, functional capacity, and consideration of choice and preference in decision making.

In addition to reforming guardianship law, New York should build upon current OPWDD regulations that recognize certain actively involved family members as surrogates for people who cannot provide their own consent.[52] By extending the authority of these people, OPWDD has minimized those instances in which guardianship is pursued. This outcome could be beneficial to all other people with disabilities to support decision-making activities without pursuing guardianship.

[52] Among other things, actively-involved family members may give informed consent for major medical procedures on behalf of individuals residing in OPWDD facilities who lack the "capacity to understand appropriate disclosures regarding proposed professional medical treatment" (14 NYCRR 633.11(a)(1)(iii)(a) and (b)), may approve service plans (14 NYCRR 681.13), object to OPWDD-related services on behalf of such individuals (14 NYCRR 633.12), may provide informed consent for behavior support plans that include restrictive/intrusive interventions (14 NYCRR 633.16(g)(6)(i)and (iii)), and make end-of-life decisions on behalf of individuals with developmental disabilities. (Surrogate's Court Procedure Act § 1750-b [1] [a]; see also 14 NYCRR 633.10 [a] [7] [iv]).

V. Ensuring Accountability for Community Integration

Although this report provides the foundation for New York's compliance with the Olmstead mandate, effective oversight is required in order to protect the rights of person with disabilities to live in the community on an ongoing basis.

Since 2011, New York has undertaken significant initiatives to ensure the protection of people with disabilities and other special needs. In June 2013, Governor Cuomo established the Justice Center to investigate and prosecute cases of abuse and neglect against people with disabilities and to provide oversight and monitoring of the systems of care serving these people. Governor Cuomo also designated Disability Rights New York as the state's federally-funded Protection and Advocacy and Client Assistance Program to provide independent oversight of these systems. Additionally, New York initiated independent ombudsman functions through Medicaid redesign to assist people with disabilities served in the Medicaid managed care system. Finally, the Governor created the Olmstead Development and Implementation Cabinet and designated a representative of the Governor's Office to direct its activities. Together, these measures strengthen the oversight of providers and service systems and provide access to independent advocacy to protect the rights of people with disabilities to live in the community.

New York's sustained attention to serving people with disabilities in the community requires continued leadership from the Governor's Office. The legislature created the MISCC in 2002 as the statutory body intended to develop New York's Olmstead plan and hold state agencies accountable.[53] As designed, MISCC had a rotating chairmanship among the commissioners of four state agencies. This model has proved challenging because one state agency commissioner does not have the authority to command other state agency commissioners. The creation of the Olmstead Cabinet, with a chair from the Governor's Office, was intended to provide leadership from the Governor's Office in the development of a plan for Olmstead compliance. To sustain this leadership over time and to hold state agencies accountable for Olmstead compliance, a representative of the Governor's Office will continue to provide leadership to the MISCC. MISCC meetings will be a continuing means of public accountability for the state's accomplishment of Olmstead goals.

In addition, the Governor's Office will develop and maintain a dashboard to monitor Olmstead compliance. This dashboard will contain key agency Olmstead initiatives and metrics to measure New York's progress in serving people with disabilities in the most integrated setting. The Governor's Office will also maintain a dedicated website, http://www.governor.ny.gov/olmstead/home. This website will provide relevant information regarding New York's implementation of Olmstead and a mechanism for the public to provide feedback regarding New York's Olmstead Plan.

[53] Additional information about past MISCC Olmstead proceedings is available at http://www.opwdd.ny.gov/opwdd_community_connections/miscc/press_releases_and_important_documents.

Conclusion

This report and recommendations, developed by the Olmstead Cabinet, provide the framework for New York to serve people with disabilities in the most integrated setting appropriate to their needs and desires. Through implementation of these recommendations, New York will:

- Assist in transitioning people with disabilities into the community from developmental centers, ICFs, sheltered workshops, psychiatric centers, adult homes, and nursing homes;
- Reform the assessment of the needs and choices of people with disabilities;
- Adopt new Olmstead outcome measures for people with disabilities;
- Enhance integrated housing, employment, and transportation services available to people with disabilities;
- Improve services to children, seniors, and people with disabilities involved with the criminal justice system;
- Remove legal barriers to community integration; and
- Assure continuing accountability for serving people with disabilities in the most integrated setting.

The effective implementation of these recommendations will safeguard the fundamental civil rights of New Yorkers with disabilities to lead integrated lives.

www.governor.ny.gov/olmsteadplan