



Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

May 6, 2024

Health Clinic Administrator

Dear Colleague:

The New York State Office for People With Developmental Disabilities (OPWDD) and the New York State Department of Health (DOH) are preparing for the submission of a new application for a 1915(b)(4) waiver to allow a selective contracting program for Home-Enabling Supports for Individuals with Intellectual and/or Developmental Disabilities. New York State assures that all Home-Enabling Supports are provided to or directed exclusively toward Medicaid eligible individuals in accordance with Section 1902(a)(10)(A)(i) of the Social Security Act.

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We are projecting that approximately 600 individuals per waiver year will be served for a total of \$3,000,000 annually. Through the selective contracting process, the state will identify multiple providers per region to ensure that providers are appropriately distributed statewide. Additionally, the state will continuously monitor providers and timely access to services to ensure that there is a sufficient supply of providers to allow for service access.

There will be no changes or diminishment of services to members of Federally-recognized Tribes. Native Americans remain eligible for services under the same rules, and, there is no change to payment rates for services provided by tribal organizations.

A draft of the waiver proposal is available for review at:
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All comments must be postmarked or emailed by June 12, 2024. Please forward comments to the State Plan Amendment mailbox email at spa-inquiries@health.ny.gov mail to:

Office of Health Insurance Programs – State Plan Unit
99 Washington Avenue
14th Floor, Suite 1430
Albany, NY 12210

We look forward to your continued collaboration.

Sincerely,

/S/

Trisha Schell-Guy, Director
Division of Program Development and Management
Office of Health Insurance Programs

cc: Melvina Harrison (CMS)
Nancy Grano (CMS)
Sean Hightower (HHS)
Michele Hamel (DOH)
Sandra Mesick (DOH)



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Saint Regis Mohawk Tribe
Chief Beverly Cook
71 Margaret Terrance Memorial Way
Akwesasne, NY 13655

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May 6, 2024

Shinnecock Indian Nation
Mr. Bryan Polite
Council of Trustees Chairman
P.O. Box 5006
Southampton, NY 11969-5006

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Executive Deputy Commissioner

May 6, 2024

Cayuga Nation
Mr. Clint Halftown
Nation Representative
P.O. Box 803
Seneca Falls, NY 13148

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Shinnecock Indian Nation
Mr. Eugene E. Cuffee II
Sachem
P.O. Box 5006
Southampton, NY 11969-5006

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Cayuga Nation
Mr. Gary Wheeler
Nation Representative
P.O. Box 803
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Seneca Nation of Indians
Mr. Maurice A. John Sr.
President
P.O. Box 231
Salamanca, NY 14779

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Executive Deputy Commissioner

May 6, 2024

Oneida Indian Nation
Mr. Ray Halbritter
Nation Representative
528 Patrick Road
Verona, NY 13478

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Executive Deputy Commissioner

May 6, 2024

Tonawanda Seneca Indian Nation
Chief Roger Hill, Council Chairman
Administration Office
7027 Meadville Road
Basom, NY 14013

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Saint Regis Mohawk Tribe
Chief Ronald Lafrance, Jr.
71 Margaret Terrance Memorial Way
Akwesasne, NY 13655

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Onondaga Nation Territory
Administration
Chief Sidney Hill
Hemlock Road, Box 319-B
Nedrow, NY 13120

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All comments must be postmarked or emailed by June 12, 2024. Please forward comments to the State Plan Amendment mailbox email at spa-inquiries@health.ny.gov mail to:

Office of Health Insurance Programs – State Plan Unit
99 Washington Avenue
14th Floor, Suite 1430
Albany, NY 12210

We look forward to your continued collaboration.

Sincerely,

/S/

Trisha Schell-Guy, Director
Division of Program Development and Management
Office of Health Insurance Programs

cc: Melvina Harrison (CMS)
Nancy Grano (CMS)
Sean Hightower (HHS)
Michele Hamel (DOH)
Sandra Mesick (DOH)



Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

May 6, 2024

Tuscarora Indian Nation
Chief Tom Jonathan
5226 Walmore Road
Lewiston, NY 14092

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JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

May 6, 2024

Unkechaug Indian Territory
Chief Harry Wallace
207 Poospatuck Lane
Mastic, NY 11950

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JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

May 6, 2024

Tuscarora Indian Nation
Chief Kenneth Patterson
1967 Upper Mountain Road
Lewiston, NY 14092

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May 6, 2024

Unkechaug Indian Territory
Latasha Austin
Keeper of Records
P.O. Box 86
Mastic, NY 11950

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Executive Deputy Commissioner

May 6, 2024

American Indian Community House
Executive Director
Patricia Tarrant
275 Madison Avenue
Suite 2014
New York, NY 0016

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Application for

Section 1915(b) (4) Waiver

Fee-for-Service

Selective Contracting Program

June, 2012

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

Facesheet

The **State** of _____ 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 _____.
(List each program name if the waiver authorizes more than one program.).

Type of request. This is:

- 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 dd years beginning _____ and ending _____.

State Contact: The State contact person for this waiver is _____ and can be reached by telephone at (____) _____, or fax at (____) _____, or e-mail at _____.
(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 (if additional space is needed, please supplement your answer with a Word attachment).

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).

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).

A. Statutory Authority

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

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. **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:

- 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:

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

C. Restriction of Freedom of Choice

1. **Provider Limitations.**

- 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 (if additional space is needed, please supplement your answer with a Word attachment).

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
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- 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
- 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 (if additional space is needed, please supplement your answer with a Word attachment)?

\

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).

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).

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).

B. 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)?

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).

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

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

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).

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).

B. Individuals with Special Needs.

____ The State has special processes in place for persons with special needs (Please provide detail).

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).

2. Project the waiver expenditures for the upcoming waiver period.

1915(b)(4) application – Section B (Cost Effectiveness)	WY1	WY2	WY3	WY4	WY5
Total people receiving Home-Enabling Supports	600	600	600	600	600
Per person maximum	5,000	5,000	5,000	5,000	5,000
Total Cost	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000