Application for a Â§1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiverï¿½s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A state has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **New York** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of ?1915(c) of the Social Security Act.

B. Program Title:
Children's Waiver

C. Waiver Number:NY.4125
Original Base Waiver Number: NY.4125.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
01/01/26
Approved Effective Date of Waiver being Amended: 04/01/22

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

This amendment updates the following:

- Adding the following new services:
  - Transitional Care Coordination
  - Transitional Services
- Modifying the FMS to include:
  - Administration of Transitional Services
  - Increasing the FMS rate for Environmental Modifications, Vehicle Modifications, Adaptive and Assistive Technology
- Removal of the C-YES/Independent Entity and allowing participants to have choice of Health Home care management
- Removal of Day Habilitation as a service under the Children's Waiver and transition to Community Habilitation , which cover the same needs however does not have the added restriction to be delivered in an OPWDD certified sites
- Allow Environmental Modifications, Vehicle Modifications, Assistive and Adaptive Technology, and Transitional Services to be purchased up to 180 days prior to discharge from an institutional setting
- Eliminating Service Dogs as allowable Adaptive and Assistive Technology
- Clarifying limits in HCBS and provisional plan of care service necessity limits for all HCBS
- Updating Environmental Modification restrictions
- Updating language regarding the ability to utilize Non-Medical Transportation
- Update language to remove references to Community First Choice Options (CFCO)
- Removal of outdated language regarding collateral contacts to more simply refer to individuals identified by the participant as well as other paid and non-paid individuals who may supervise or provide care to the member
- Removal of references to Teaching Family Homes, which no longer exist in New York
- Language in the Environmental Modification, Vehicle Modification, and Adaptive and Assistive Technology definitions has been clarified to refer to an established limit per service and that limit cannot be exceeded without special circumstances, medical necessity documentation meeting specific NYSDOH requirements, and prior approval from FMS/NYSDOH
- Clarified that community habilitation direct service worker and supervisory staff must have at least a high school diploma or equivalent education
- Clarified community habilitation teaching tasks which are allowable versus direct provision of health-related tasks by staff, which are not allowable
- Changed Vehicle Modification provider qualifications from ACCESS VR to National Mobility Equipment Dealers Association (NMEDA)
- Removed wording that OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General because this is already a Medicaid provider enrollment requirement for all providers and their employees
- Clarified in Environmental Modifications that the practice of "balance billing" or requiring/allowing families to fund some of the cost of a service from their own funds is prohibited under Federal and New York law.
- Clarify target populations.
- Clarify that state staff will perform evaluations when individual is not yet Medicaid eligible.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	Public Input
☒ **Appendix A ? Waiver Administration and Operation**	A-3,4,5,6 QIS-A
☒ **Appendix B ? Participant Access and Eligibility**	B-1b,c, 6b,c,d,f,i,j QIS-B
☒ **Appendix C ? Participant**	C-1/C-3, 4,5, QIS-C

Component of the Approved Waiver	Subsection(s)
Services	
☒ **Appendix D ? Participant Centered Service Planning and Delivery**	D-1, D-2, QIS-D
☒ **Appendix E ? Participant Direction of Services**	E-1,E-2
☒ **Appendix F ? Participant Rights**	F-1, F-3
☒ **Appendix G ? Participant Safeguards**	G-1, G-2
☒ **Appendix H**	H-1, QIS-H
☒ **Appendix I ? Financial Accountability**	I-1,QIS-I, I-2, I-3
☒ **Appendix J ? Cost-Neutrality Demonstration**	J-2, Yr 4-5

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☒ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☒ **Add/delete services**
- ☒ **Revise service specifications**
- ☒ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☒ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☒ **Other**

Specify:

Language updates throughout to remove references to the Independent Entity/C-Yes and to add references to state staff performing eligibility. Transition Care Coordination and Transition services have been added throughout the application. All other changes noted in the Purpose of the amendment were also made. Note the change to the target group was just a clarification and did not effect eligibility.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **New York** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Children's Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NY.4125
Draft ID: NY.019.06.03

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/22
Approved Effective Date of Waiver being Amended: 04/01/22

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☒ **Hospital**

Select applicable level of care

◉ **Hospital as defined in 42 CFR § 440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Hospital Level of Care for Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160 is also included in this waiver but the selection is not permitted by the portal"

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**

☒ **Waiver(s) authorized under section 1915(b) of the Act.**

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

NY.050 FMS Sel Contract Children’s waiver FMS Selective Contracting 03/01/2024

Specify the section 1915(b) authorities under which this program operates *(check each that applies):*

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☒ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under section 1915(i) of the Act.**

☐ **A program authorized under section 1915(j) of the Act.**

☒ **A program authorized under section 1115 of the Act.**

Specify the program:

CMS approved New York's request to amend its section 1115(a) demonstration titled, "Medicaid Redesign Team" (MRT) (Project Number 11-W-001142/2} on August 2, 2019. The approval enabled the state to create a streamlined children's model of care for children and youth under 21 years of age with behavioral health (BH) and HCBS needs, including medically fragile children, children with a BH diagnosis, children with medical fragility and developmental disabilities, and children in foster care with developmental disabilities.

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The New York State (NYS) -DOH Children's Waiver operates concurrently with the State's 1115 MRT demonstration waiver and a 1915(b)(4) waiver. The New York State (NYS) -DOH amendment which consolidated and administratively aligned the state's children waivers under the current Children's Waiver program went into effect on April 1, 2019.
As of October 1, 2019, the Children's Waiver began operating concurrently with the State's 1115 MRT waiver. HCBS services are provided by Managed Care Organizations (MCOs) for children in managed care beginning October 1, 2019. Children in FFS will continue to receive HCBS via the FFS delivery system. The Children's Medicaid waiver includes specifically:
-Incorporates the Serious Emotional Disturbance (SED), Medically Fragile, and foster care with developmental disabilities.
-Incorporates the aligned HCBS descriptions and provider qualifications into this waiver
-Includes all levels of care (hospital, nursing facility, and ICF/IIID).
-Includes the use of an algorithm based on a subset of the CANS-NY, housed in the Uniform Assessment System (UAS-NY) for all community-based programs for hospital and nursing facility LOC. ICF-IID LOC determinations will continue to be made utilizing the DDRO ICF-IID determination tool. Please refer to Section B-6 (c-d).
-Includes case management descriptions from the State's Health Home SPA for children.
The concurrent implementation of the 1115(a) demonstration provides a streamlined model of care for children and youth under 21 years of age with BH and HCBS needs, including medically fragile children, children with a BH diagnosis, children with medical fragility and developmental disabilities, and children in foster care with developmental disabilities, by allowing managed care authority for their HCBS. The concurrent authorities will improve health outcomes for children and youth with BH and HCBS needs by addressing needs early in childhood and before they escalate and become more costly and complex in adulthood. The concurrent 1115 Demonstration integrates the delivery and care planning of behavioral and physical health and community supports, and increase network capacity. Participants are allowed to self-direct Adaptive and Assistive Technology, Environmental Modifications, Transitional Services, and Vehicle Modifications through an FMS.

Remote training for use of the Adaptive and Assistive Technology is provided at the time of the service being provided and is not ongoing support or monitoring. The State Medicaid Agency and FMS ensures the health and safety of waiver participants when their services are delivered via telehealth/remotely through an incident management system, established health care standards, and monitor those standards based on the responsibility of the service provider. HHCMs use the incident management system, health care standards and monitoring to ensure that remote delivery of training is consistent with the waiver standards. The participant may request the training be fully remotely 100 percent of time with no in-person. HHCMs monitor the remote training delivery for Adaptive and Assistive Technology according to the acuity contact schedule. Remote training delivery allows the participant to receive the Adaptive and Assistive Technology more quickly, resulting in youth avoiding institutional placement or placement in a more restrictive living environment or transitioning from those care settings more quickly. This will allow youth to enhance/increase the individual's independence and to fully integrate in the community and participate in community activities. Remote training delivery will only be utilized when the training may be appropriately delivered remotely. The training is not anticipated to be on-going and will not violate the family or participant's privacy. The training will be delivered through HIPAA compliant methods in a manner accepted by the State's HIPAA compliance officer. The Adaptive and Assistive Technology goals and training modality will be discussed with the family and documented in the individual's person-centered service plan prior to use. The plan will document the type of delivery of training needed and requested by the child and family. The HHCMs will ensure that the child/youth's needs are being addressed including understanding how to use Adaptive and Assistive Technology and that health and welfare needs are being addressed. As a back-up in the event of technology failure, the remote training will be rescheduled. The child/youth and family may remotely receive the training associated with the Adaptive and Assistive Technology in the room of their choice (not the bedroom or bathroom) and they may turn the training off if they so choose. They will be informed of this choice during their person-centered planning meeting. See the Adaptive and Assistive Technology service description.

Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID pandemic, a quality review report was not completed for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been submitted. Upon expiration of the Appendix K amendment, NYS-DOH will gather data and submit the quality review in addition to any outstanding 372 reports as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 report(s) within 90 days of receiving the final quality review report and 372 report acceptance decision.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in section 1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by

geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR § 441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver

and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's

procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

NYSDOH staff and state agency partners work closely on a continuing basis with advocacy groups for families of children with disabilities and waiver service providers. A service provider summary of the MRT meetings since 2011 can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/web-info_child_mst.htm

The original 1115 waiver notice of the concurrent operation of children's HCBS in managed care was noticed on July 5, 2017.

The State published public notice of this amendment from July 2, 2025 to August 2, 2025 for 30 days at the following website: (ny.gov) The proposed waiver at the following website: Overview of 1915c Children's Waiver and 1115 Waiver (ny.gov) 0 comments were received, and no actions were taken.

The State published the entire 1915(c) waiver renewal and the notice on 01-05-2022 at the following website: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1915c_waiver_renewal.htm

The State published public notice from 01-05-2022, for 30 days until 02-04-2022 in the New York State Register for this renewal.

The notice included an address to submit comments to the Department of Health.

Pursuant to Presidential Executive Order #13175, NYSDOH provided the State's nine federally recognized Tribal Governments with written notification of the children's waiver application and all proposed substantial changes to the program and offered an opportunity for their comment. Notice to the tribes was sent to the tribes on 12-22-2021, regarding this specific renewal. The notice included an address to submit comments to the Department of Health.

Public Notice:

This link was live on 01-05-2022.

The following comprises the public comments from the official public input received on the renewal during the official public comment period.

Positive Comments:
-We appreciate that DOH has reduced paperwork including LPHA form changes and streamlined administrative redundancies, lessened provider experience requirements, improved respite and expanded options in place of face to face meetings.
- The DOH HCBS designation list and capacity Map/Spreadsheet are helpful.
-We appreciate the rate enhancements through the Appendix K process.
- We support the proposed Participant-Directed Goods and Services, and Medical Respite amendments proposed later in 2022.

Complexity: The health care delivery system, HCBS Waiver and other NYS Medicaid funded services are increasingly more complex. We recommend that DOH create a single overarching procedure and audit protocol and require all health homes to have a single care plan and interoperability across systems/platforms, including:
- Streamline the current 5201 and 5055 consents
- Allow CMs to complete the DOH-5152 using the most recent IEP/IFSP/504 plan.
- Permit CMs to use bank statements showing receipt of SSI as proof of LOC.
- Reform C-Yes.
-Clarify the AAT, E-Mod and V-Mod process.
Response: NYS is continually working to streamline administrative process and proposes eliminating unnecessary paperwork and redundant documentation requirements in the Waiver request.
-The renewal request proposes removal of the LPHA attestation requirement for the MF/DD populations.
-NYS is developing stakeholder sessions to learn more specifics on administrative issues and barriers such as documentation.
- The state has been continuously examining C-YES processes to improve workflow since it rolled out, and has seen dramatic improvements. To continue to make the process easier for families, education materials have been developed by

C-YES that walk the family through each of the steps of working with C-YES. The renewal request proposes expansion of the Independent Entity Independent Evaluator Nurse qualifications to allow the contractor to hire additional staff to continue to be able to improve processing time frames.
- The Department will continue to examine the EMOD/VMOD/ATECH processes to reduce the length of time and effort involved in reviewing an approving these requests. A more streamline approach is likely to be incorporated into a future waiver amendment.

Staffing challenges leading to capacity issues:
-Staffing challenges and workforce challenges leading to capacity restraints.
-Current rates are insufficient and unsustainable.
-Lack of HCBS services for those eligible resulting in long wait lists and increased risk to hospitalization and out-of-home placement.
-Rate disparities across services are not well understood.
- Cost to implement EVV was never reimbursed.
- The 25% rate increase should be applied to Health Home providers as well.
Response: The renewal proposes a 25% rate increase over historic Children's waiver rates through September 30, 2022, consistent with the Department's Spending Plan for Implementation of Section 9817 of the American Rescue Plan Act of 2021, to improve service capacity. It also proposes a revised rate setting methodology to be based on historic Children's provider cost reports to be implemented effective October 1, 2022. An amendment in the fall of 2022 is anticipated to include an HCBS LOC/POC annual assessment fee. The 25% rate increase applies to all services under the HCBS waiver. An additional fee for Health Homes is being negotiated with CMS for timely completion of HCBS assessments and care plans.

See "b. Optional" for the rest of the public comments from the official comment period. Attachment A has public input summaries gathered prior to the official comment period.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the state of the state's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Poulin

First Name: Colette

Title: Health Program Director, Children's Health Home

Agency: New York State Department of Health, Office of Health Insurance Programs

Address: One Commerce Plaza

Address 2: Room 720

City: Albany

State: **New York**

Zip: 12237

Phone: (518) 486-4052 **Ext:** ☐ **TTY**

Fax: (518) 486-2495

E-mail: Colette.Poulin@health.ny.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Hamilton

First Name: April

Title: Deputy Director, Division of Program Development & Management

Agency: NYS Department of Health, Office of Health Insurance Programs

Address: One Commerce Plaza

Address 2: Room 720

City: Albany

State: **New York**

Zip: 12237

Phone: (518) 473-0919 **Ext:** ☐ **TTY**

Fax: (518) 486-1346

E-mail: april.hamilton@health.ny.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions

of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **New York**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Timeline for Managed Care provision of HCBS for children enrolled in MCOs. No earlier than the second year of the waiver will the HCBS be capitated.

The NYS DOH has conducted stakeholder meetings throughout 2021 to prepare the Children's Waiver renewal. Below is a summary of public comments received prior to the official federal public notice period and resulting proposed changes to the Children's Waiver:

1. Administrative Burden: Care managers have high caseloads and must gather repetitive data which is then entered multiple times. There is a lack of collaboration between HHCM and HCBS providers.
Response: NYS is continually working to streamline administrative process and proposes eliminating unnecessary paperwork and redundant documentation requirements in the Waiver request.

2. Education and Participation: Providers would benefit from education on POCs, home and vehicle modifications, incident reporting, and use of HCBS. Regular stakeholder meetings are requested to discuss barriers and concerns. More advance notice for trainings is needed. Improved coordination between the LGU/C-SPOAs and HHCMs was requested. Education of hospital staff was requested about the waiver.
Response: The renewal request proposes a broader definition of caregivers eligible for training to include all individuals who supervise and care for members. The State has provided direct feedback to individual providers to improve POC quality through case file reviews. The State has initiated a series of webinars on person-centered planning, home and vehicle modifications, incident reporting, and POC development and maintenance as a result of the stakeholder meetings. The State has developed and deployed a new POC training for all HHCMs. The State has posted webinars/training materials to the website as well as recordings of the trainings to allow all individuals access to the training regardless of notice. NYS is examining how to incorporate various stakeholders in a rotating meeting series throughout the year. NYS is working with the Office of Mental Health and the SPOAs to incorporate them within the HCBS process to assist with the access to behavioral health services. NYS will develop a promotional/educational plan for outreach to hospital staff.

3. Qualified Practitioners and other staff: Stakeholders are concerned about high qualifications requiring degrees and extensive experience at a time when there is a workforce shortage and low reimbursement rates. SPOA's and Child Welfare / Protective Services requested the ability to determine eligibility to help alleviate workforce shortages. Providers requested enhanced peer and family support services training and credentialing using State partner agencies.
Response: The renewal proposes changes the IEIE qualifications to allow more individuals to qualify for this role. The State is also reviewing ways to enhance training or certification for staff who complete the Level of Care determination and provide HCBS.

4. Rates, Staffing, Access & Waitlists: The lack of an adequate number of providers has resulted in waiting lists for children on the waiver. Providers reported difficulty in hiring and retaining staff, citing low reimbursement rates. Providers requested that the State should move back to bundling State Plan behavioral health services with HCBS services. Providers also requested that DOH allow children to start services prior to eligibility determinations under the waiver.

Response: The renewal proposes a 25% rate increase over historic Children's waiver rates through September 30, 2022, consistent with the Department's Spending Plan for Implementation of Section 9817 of the American Rescue Plan Act of 2021, to improve service capacity. It also proposes a revised rate setting methodology to be based on historic Children's provider cost reports to be implemented effective October 1, 2022. An amendment in the fall of 2022 is anticipated to include an HCBS LOC/POC annual assessment fee. Bundled State Plan and HCBS FFS rates are no longer allowable with the Centers for Medicare and Medicaid Services. The purpose of establishing State Plan authority for children's behavioral health services is to ensure that they are available to meet the needs of children before their condition progresses. Bundling these services with HCBS and limiting them only to children who meet waiver eligibility criteria, would reduce access and limit provider's ability to intervene early.

5. Documentation: Stakeholders reported that onerous paperwork takes time away from families. The paperwork does not align with the needs of MF or children with trauma. Providers requested the elimination of the LPHA form, HCBS Authorization and Care Manager Notification forms, particularly when children/youth transition from an institution. There is confusion around how to process renewal documentation. Commenters suggest that the state should streamline the HCBS referral process, consent protocol, DOH-5152 and 5201 forms. Each HH uses its own forms and providers find this confusing and difficult.
Response: The renewal request proposes removal of the LPHA attestation requirement for the MF/DD populations. NYS is developing stakeholder sessions to learn more specifics on administrative issues and barriers such as documentation.

6. Communication: Stakeholders reported that HHs and providers need to communicate better. Low reimbursement rates were cited as contributing to the lack of communication by HCBS providers with HHCMs. DDRO communication is difficult.

Provider agencies often do not know when there are multiple providers serving a single family (e.g., CFTSS and HCBS).
Response: NYS is examining ways to foster better communication between providers and HH care managers. Since the stakeholder forums, the Department of Health has been working with the Office for People With Developmental Disabilities to address the concerns regarding communication with the DDROs.

7. Roles: Counties/LDSS reported being unaware of their roles and responsibilities when asked to approve and facilitate requests for Environmental, Vehicle Modifications and Assistive Technologies. DOH must identify issues and improve upon administration of both Transportation (MAS/Medicare) and EMOD/VMOD/ATECH services. DOH should centrally manage EMODs.
Response: The Department will continue to examine the EMOD/VMOD/ATECH processes to reduce the length of time and effort involved in reviewing an approving these requests. A more streamline approach is likely to be incorporated into a future waiver amendment.

8. Service array: Stakeholders requested that DOH change the name of Palliative Care: Bereavement and add Transition Services to help children transition from institutions. They also requested a streamlined service array to maximize the available workforce with focus on respite including medical respite. Stakeholders requested that the state implement CFCO services for children only needing home and vehicle modifications and implement intensive in-home supervision or Intensive-Transition Care Support to the waiver.
Response: The renewal proposes changing the Title of Palliative Care: Bereavement to Palliative Care: Counseling and Support Services; and streamlines Caregiver and Family Support and Services and Community Self-Advocacy Support into a new service called Caregiver/Family Advocacy and Support Services. This new consolidated service allows an expanded array of providers to provide the enhanced service definition. An amendment in Fall 2022 is anticipated to add Medical Respite and transition coordination and services. NYS will be adding High Fidelity Wraparound to the HH State Plan in Fall 2022.

9. Service Delivery Methods: Stakeholders requested that DOH maintain telehealth services including telephonic support for parents because monthly face-to-face meeting requirements are not a good use of time for children with numerous providers involved, including in the home. There was concern on limits on the number of hours that a child may receive a service in a single day.
Response: The State is considering sustainable policies to allow telehealth practices, where appropriate. The State is also considering the development of policies for acuity vs. safety assessment to determine appropriate face-to-face requirements based on families' needs.

10. Improving Use of Information Technology: Stakeholders requested a system to improve coordination and referrals among agencies providing services to children. Stakeholders requested increased use of Health IT and systems already in place.
Response: The State will be providing HCBS claims data within the HH Medicaid Analytics Performance Portal (MAPP) HH Tracking System for lead HHs and CMAs to be aware in a new release the first quarter of 2022. The State is building an electronic Capacity Tracker to provide information on waitlists and referrals for HH, CMAs, and provider services. The NYS HH program is collaborating with the HH Coalition, lead HHs, and CMAs to examine workload and administrative burden. The HH/Managed Care committee has been working at entering the POC in the MAPP platform.

11. Population Needs: Children who are MF should have specialty care managers. Children who are DD could benefit from an expedited approval process at the DDROs. Children who are SED would benefit from intensive care coordination.
Response: Medicaid financial eligibility processes must be followed for all children entering the waiver. The State has already begun to engage the HHs and the medically fragile CMAs in a discussion regarding the needs for the medically fragile/complex population. NYS is considering adding high fidelity wraparound to the HH model under the State Plan.

12. Children and Youth Evaluation Services (C-YES): Stakeholders commented that families who selected C-YES find it a cumbersome, bureaucratic barrier to accessing care.
Response: The State acknowledges that implementation challenges resulted in lengthy assessment timeframes when C-YES first launched. The state has been continuously examining C-YES processes to improve workflow since it rolled out, and has seen dramatic improvements. To continue to make the process easier for families, education materials have been developed by C-YES that walk the family through each of the steps of working with C-YES. The State encourages families and providers to report issues to the Managed Care complaint line when necessary. The renewal request proposes expansion of the Independent Entity Independent Evaluator Nurse qualifications to allow the contractor to hire additional staff to continue to be able to improve processing time frames.

13. Managed care: There are issues with timely reimbursement from MMCPs, service denials, lack of understanding of population served.
Response: If these issues cannot be resolved by working directly with managed care plans, providers should report these issues to

the DOH Managed Care Division at 1-800-206-8125 OR managedcarecomplaint@health.ny.gov.

14. Clinical service availability: There are no clinical services for the SED kids in the waiver any longer.
Response: All clinical behavioral health services have been moved to the Medicaid State Plan and no longer require a child to meet targeting and functional criteria required for waiver participation. Any child meeting medical necessity may receive clinical behavioral services now under the Medicaid State Plan.

15. State Plan service access: CFTSS should be contacted first to see if these services will be adequate. If a youth meets HCBS eligibility they should be automatically eligible for CFTSS services without the need for additional medical necessity.
Response: NYS agrees that Behavioral Health State Plan services (CFTSS) should be utilized when medically appropriate for each individual child. However, not all children in the Children's Waiver will need CFTSS.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Continued from 6. Public Input - Comments received during official Public Comment period.

Care Management and Medicaid eligibility: Care Management has been removed from the Children's Waiver. DOH should allow for Care Management as a waiver service and count as a waiver services at least monthly or modify the criteria for frequency of services to monthly monitoring. DOH has failed to mention structures for the provision of Care Management as a waiver look-alike service to clients who are Family of One and not in need of or able to receive other waiver services.
Response: Children eligible for HCBS under the Children's waiver now receive their care management under the Health Home authority or C-YES program. This alternative authority has not affected eligibility for Medicaid because under the 1115 Demonstration, HCBS eligible children with Family of One Medicaid receiving only Health Home services continue to be eligible for Medicaid under that authority (not the 1915(c) Children's Waiver). All explanations of the 1115 Demonstration are outside of this Children's 1915(c) waiver and may be access at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82656.

Remote Training for Adapt

ive and Assistive Technology: Care Managers should not oversee training and implementation of AAT. LDSS/DOH or MCOs are the provider of record and must assume that responsibility. The Waiver renewal prohibits training in a bedroom or bathroom, which is where the AAT is utilized.
Response: CMS required language regarding privacy in the bedroom and bathroom and monitoring of training by Care Managers (non-providers).

Public Input: MRT meetings no longer occur, and minutes have not been posted since 2018. Meetings with Health Homes and MCOs exclude Care Management agencies, Community Based Organizations, families, and service recipients.
Response: There are a number of other meetings that are held for various types of stakeholders. NYS is examining ways to foster better communication between providers and HH care managers and other stakeholders.

Managed Care: Managed Care involvement has convoluted effective service access and delivery. MMC added administrative burdens and costs related to claims processing, service management, Managed Care Billing/Reimbursement delays threaten provider sustainability.
Providers should be reimbursed directly through Medicaid claims and DOH should assume the role of navigating the exchanges and collecting reimbursement from the MCOs. Care managers would like to Medicaid Claims Detail Reports to include Medicaid encounter data for managed care waiver enrollees. MMCPs are denying critical EPSDT services to Medically Fragile children. Increases in Fair Hearings related to MMCP service denials, EMODS, Transportation, DME and Nursing. Managed Care Plans lack understanding of HCBS & specialty (medically fragile) populations across Plans. Each MMCP has their own set of contacts/requirements, Plan of Care language and sharing expectations. Many clients with TPHI have been erroneously auto-enrolled into Medicaid Managed Care.
Response: If these issues cannot be resolved by working directly with managed care plans, providers should report these issues to the DOH Managed Care Division at 1-800-206-8125 OR managedcarecomplaint@health.ny.gov.

Complaints: Complaint processes for FFS children should be clarified.
Response: The State encourages families and providers to report issues to the Managed Care compliant line when necessary.

Target Group Criteria: DOH references Forms OHIP 0005, OHIP 0006 and OHIP 0007. Those forms are now defunct and were replaced by the 5151, 5152, 5153 forms.
Response: Thank you this change will be made.

Maximum Age Limitations: Can individuals remain on the Children's Waiver and continue to be served through the Health Home Serving Children model beyond age 21?
Response: No, children cannot remain on the Children's waiver beyond age 21.

LOC, POC and authorization frequency: DOH should remove the statement "in conjunction with the POC" in reference to the annual evaluation.
-Authorizations should be annual and not every 6 months.
-The HCBS authorization form needs to accurately reflect all various HCBS services.
- Community Habilitation authorizations should be based on outcomes. Respite authorizations should include a lump sum authorization such as that authorized under OPWDD waivers.
-DOH should clarify the documentation needed to request additional hours. Service Guidelines need to be consolidated.
- Certain elements of the palliative workflow remain insensitive to families who are grieving the loss of a child.
Response: It is expected that the eligibility evaluation will be conducted annually and that the POC will be reviewed in

conjunction with that updated evaluation.

Access to Services by Limited English Proficient Persons: Certain Lead Health Homes have communicated that provision of translation services is not their responsibility, which is contradictory with waiver assurances.
Response: HHs are required to work with their contractors to ensure translation. The providers should refer to their contracts with HHs on how translation is arranged and reimbursed for every member.

Respite-Personal Care:
Is there a limit on units (hours) per day or per year? What are the reimbursement rates? Will there be considerations made for patients who are infants and young children who require high levels of supervision and support and due to age, are unable to perform independent tasks? DOH should reconsider allowing relatives and guardians to provide these services. Do not limit hourly respite to 6 hours in a given day. Temporary-emergency respite represent a one-time authorization; currently, there is no real mechanism (with the MMC plans with whom we have been working) to obtain this level of authorization.
Response: Please see the HCBS manual and rates posted at:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/manuals.htm All rates are published at the above website. There are no hard limits on the number of units per day or year, however, the delivery is expected to be short-term and not result in a child living in an institutional or having a permanent alternative caregiver.

Non-Medical Transportation. The process should be the same whether the client is FFS or enrolled in managed care.
Response: NYS will examine where the processes differ and the purpose.

Fair Hearing Rights/Privacy Act: Families have the right to choose who will represent them at a hearing. DOH contracts with Health Homes to make LOC determinations which impact Children's Waiver eligibility/enrollment and dis-enrollments. Health Homes should not be called upon to act as the representing agent for NYSDOH for fair hearings that pertain to other non-Health Home services. DOH should re-review the Privacy Act and Conflict of Interest requirements.
Response: As a contractor to the State of New York, Health Homes are contracted to make eligibility determinations on behalf of the State agency and represent the agency at fair hearings. This includes access to information regarding the family. The family may choose anyone to represent them at the hearing other than the Health Home, who contractually represents DOH.

E-Mods and V-Mods: What are the safeguards and firewalls that will be required of Health Homes who are providers of record for E-Mods and V-Mods.
Response: Health Homes are required to have conflict free case management safeguards and protections as part of their structure under 1945 of the Social Security Act. The overall structure of Health Homes meets the HCBS conflict of Interest standards.

OPWDD and DOH services
DOH should align its services with OPWDD. DOH should clarify which providers are not authorized to deliver medical care/treatment.
Response: The Department will continue to work with OPWDD to clarify and streamline processes.

Technical Edits
Please add "but is not limited to" to the term "includes" in the AAT definition because EPSDT is not limiting.
Response: Any EPSDT DME service is outside of the Children's waiver and under the Medicaid State Plan.

Appendix I1 continued
Independent Audit:
Since 1/1/23 New York requires Community Habilitation and Respite providers to utilize EVV in certain circumstances, if they are provided in the individuals home not paid as a per diem, not provided by a live in caregiver.

Appendix I-2a continued

Public Input Process and Rate Sufficiency
New York utilized the public input process in Main section 6-I to solicit public comments on reimbursement methodologies. New York will ensure rate sufficiency consistent with the November 2016 and January 2019 technical guide to ensure access to services including:

1. Date the rates were initially set and last reviewed: Children's Waiver - Because this is a major program change, New York reviewed and set the rates for the Children's waiver effective April 1, 2019 and revised the rates with the renewal effective April 1, 2022.

2. NY measures rate sufficiency and compliance with §1902(a)(30)(A) of the Act: DOH will utilize techniques outlined in the CMS training Ensuring Rate Sufficiency: Rate Review and Revision Approaches – November 2016 to ensure access

3. The rate review method(s) used: DOH will utilize the following three methods.

-Analyze and incorporate feedback from stakeholders specifically
o Collect data on Fair Hearings, grievances or complaints related to lack of providers
o Complement Fair Hearing and grievance/complaint information with data from individual and provider surveys
-Collect evidence from QIS D, Sub-assurance whether services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan. If individuals are not receiving services in accordance with the service plan, it could indicate that there are insufficient providers to meet individuals' needs.
-Measure changes in provider capacity. Measure the change in the number of new providers and those providers' capacity following a change in waiver service rates. Request provider capacity information approximately a year after the rate change. Compare provider capacity information to the percentage change in enrollment for the previous two years or more.

4. The frequency of rate review activities: DOH will review the feedback from stakeholders, evidence from QIS D, and changes in provider capacity at least annually.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

◉ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

◉ **The Medical Assistance Unit.**

Specify the unit name:

Office of Health Insurance Programs (OHIP)

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that

division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

For enrollees in FFS, Health Homes assess children and conduct plan of care development and carry out the plan of care that supports the child's functional development and inclusion in the community. SPOAs may conduct evaluations for children with SED. A state staff meeting the qualifications outlined in Appendix B-6 will conduct the level of care evaluation, for Family of One children who are not eligible for Medicaid yet, the State's staff performs functions related to the functional eligibility determination. Once the child is eligible for Medicaid, the child will select a Health Home for HCBS case management. Health Homes will refer applicable children to the DDRO for ICF-IID LOC determination and re-determination and will enter the information in the UAS. After DDRO review, Health Home will confirm that the child's LOC meets the HCBS eligibility qualifications. The child's application is part of the UAS subject to NYSDOH staff review. The LDSS will perform any financial eligibility steps necessary to finalize HCBS eligibility. NYSDOH or its designee will send a letter of approval or denial which is addressed to child/family. All subsequent evaluations and assessments are maintained at the Health Home and subject to NYSDOH review.

The HHCM monitors and oversees the implementation of the POC through frequent communication with participants/parents/legal guardians.

For enrollees in managed care, the state's contracted Managed Care Organizations (MCOs) are responsible for contracting with Health Homes that assess children and conduct plan of care development and carry out the plan of care that supports the child's functional development and inclusion in the community. Health Homes will refer applicable children to the DDRO for ICF-IID LOC determination. The child's MCO will ensure related service authorizations are in accordance with the Plan of Care, review POCs, assist with utilization management by reviewing the POC to ensure that all assessed needs are met and that the POC complies with federal requirements, conduct provider credentialing, provider manual, and other provider guidance; and participate in the comprehensive state quality improvement strategy for the MRT program including this waiver. The State's External Quality Review Organization will perform managed care reviews including calculation and/or validation of performance measures per federal requirements at 42 CFR 438 subpart E. The HHCM monitors and oversees the implementation of the POC through frequent communication with participants/parents/legal guardians and providers. The MCO also reviews the POC for managed care enrollees.

New York State Technology Enterprise Corporation (NYSTEC), as the quality improvement contractor, will perform quality improvement activities on behalf of the State Medicaid Agency as noted throughout the renewal.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☒ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Developmental Disability Regional Office (DDRO) will have UAS-NY eligibility access to complete the ICF/IID LOC for children requiring that LOC. The NYS Mental Health Single Points of Access (SPOA) may conduct LOC determinations for the SED population. The DDRO and SPOA will refer the child back to the HH for the plan of care development. DOH reviews MA regulatory and operational functions for the DDRO LOC determinations through the in consultation with other DOH Divisions including the Division of Legal Affairs as needed.

In New York State, the Local Departments of Social Services (LDSS) and Human Resource Administration (HRA) in New York City will continue to conduct financial eligibility determinations.

The respective roles and responsibilities of the State and the LDSS are established by Sections 201 and 206 of the Public Health Law, Sections 363-a and 366.6 of the Social Services Law, and by the Medicaid (MA) State Plan. In addition, NYS bulletins, General Information Systems (GIS), and MA Management Administrative Directives (ADM) are issued and updated as needed to provide ongoing guidance regarding MA program administration. Accordingly, no additional Memorandum of Understanding between the State and an LDSS is necessary. This includes HRA, which covers New York City's five boroughs.

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The OHIP is responsible for the day-to-day operation and oversight of the Children's FFS delivery system and is, accordingly, responsible for oversight of Health Home program, including standards requirements and roles and responsibilities.

The OHIP managed care staff are responsible for the day-to-day operation and oversight of the Children's MC delivery system and are accordingly responsible for assessing the performance of the MCO waiver administration which includes the roles and responsibilities of Health Homes contracted by MCOs. The State's External Quality Review Organization will perform managed care reviews including calculation and/or validation of performance measures per federal requirements at 42 CFR 438 subpart E.

Interagency Monitoring Team (IMT), chaired by NYSDOH staff, with representation from State children's services agencies will collect the reports outlined in the waiver application and review at least quarterly to ensure that the specialized needs of various populations included within the Children's waiver are met.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

DOH OHIP in conjunction with other DOH divisions assess the performance of the contractor's participation in a variety of ways. The summary of DOH findings from program assessment activities are provided in the annual 372 narrative.

The DOH FMG monitors, through OMIG, funds spent on the waiver using the audit pool and performance measures and 95% CI sampling methodology outlined in Appendix I-1.

DOH has regular meetings with the MCOs, HCBS providers and Health Homes to discuss MCO and FFS reports, fiscal and program data and HCBS assurance data.

DOH conducts annual site visits at each MCO to assess the plan's performance including oversight of the MCOs enrollment processes, ensuring that the MCO has utilization procedures and prior authorization processes in place to review waiver expenditures against approved levels, credentialing of providers, and quality assurance and quality improvement activities.

The State's External Quality Review Organization will perform annual managed care reviews including calculation and/or validation of performance measures per federal requirements at 42 CFR 438 subpart E as well as other managed care regulations.

The DOH, through its quality improvement contractor (NYSTEC), reviews an annual sample of POCs checks for signatures and timeliness of assessments, as well as reviewing the sign off on level of care certifications for Health Homes. NYSDOH OHIP staff oversee and monitor the administration of the Children's waiver through annual case record reviews designed to assess the MCO/Health Home understanding of its role and responsibilities, and waiver administrative processes. All applications along with the level of care determinations are entered in the UAS, and participant POCs are submitted to the MCO and maintained by the HH and subject to NYSDOH review. Once the applicant is enrolled in the Children's waiver, NYSDOH staff oversees and monitors the administration of the Children's waiver through annual case record reviews designed to assess the waiver functions.

The Health Home are required to maintain information in the State's database that tracks information regarding applications, authorized participants, dis-enrolled participants, and applicants denied waiver participation. Health Home are also required to submit summaries of reported participant complaints or dissatisfaction with services or providers of services. These reports and records are used to assess waiver administrative performance.

Health Home Care Managers, MCOCC, and NYSDOH will track and trend complaints/grievances received and resolve those issues consistent with contractual requirements and federal regulations. This process is ongoing, not limited to quarterly reports made to NYSDOH. Health Homes are responsible for investigating and responding to complaints that are received.

NYSDOH maintains a 1-800 number to receive complaints (1-800-206-8125) and managedcarecomplaint@health.ny.gov. The OHIP Division of Health Plan Contracting and Oversight operates a complaint system that accepts complaints from enrollees, their designees and providers regarding the access to and quality of care received. The MCOs are also required under 438 Subpart F to maintain a complaint and Grievance system outlined in Appendix F of this document. DOH and the Interagency Monitoring Team will review issues as outlined in Appendix H as well as providing DDRO, FMS and LDSS oversight as needed. DOH staff receives a copy of complaints and conferences with the Health Home to ensure proper investigation is done according to established procedures. NYSDOH staff will hold conference calls with the Health Home and the complainant if NYSDOH staff determines that the situation warrants it.

NYSDOH staff participate in a variety of activities to provide technical assistance in order to maintain an open line of communication with the Health Home/MCO and investigate complaints. For example, quarterly conference call meetings with the Health Home/MCO staff statewide, provide opportunities for information updates and discussion of issues to ensure consistency in policy interpretation and implementation. Power point slides and Frequently Asked Questions are developed as needed.

NYSDOH staff participate in training and other meetings such as the statewide MCO and Health Home meetings. These meetings provide an opportunity for information and feedback about administrative issues, encourage discussion of common concerns and interests, and development of corrective activities that directly impact the Children's waiver.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☒	☒
Waiver enrollment managed against approved limits	☒	☐	☐
Waiver expenditures managed against approved levels	☒	☒	☐
Level of care waiver eligibility evaluation	☒	☒	☐
Review of Participant service plans	☒	☒	☐
Prior authorization of waiver services	☒	☒	☐
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☒	☐
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐	☐
Quality assurance and quality improvement activities	☒	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other

appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of initial level of care (LOC) determination forms present in records sampled by NYSDOH staff where the notice of decision (NOD) was completed within thirty days of the initial LOC (N Number of initial LOC forms present in the HH record where the notice of decision (NOD) was completed within thirty days of the initial LOC / D Total records sampled)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
LOC forms

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5% margin of error
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver providers who have an active agreement with the State to provide Medicaid services (N Number of waiver providers with an active Medicaid agreement / D Total waiver providers).

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
provider agreements

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of MCO data reports that were submitted on time and in the correct format (N Number of data reported received timely and in correct format / D Total reports due).

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Tracking reports:
Monthly reports from Health Homes/MCOs are used as a tracking tool to monitor program activity. Many reports can be pulled directly from the State's Medicaid Analytics Performance Portal (MAPP) and Uniform Assessment System (UAS) by OHIP staff. Ongoing monitoring of service utilization and expenditures.

Conference calls:
Regular conference calls enable the sharing and peer discussion of HCBS issues. NYSDOH staff may also present new directives or waiver topics.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The remediation process is initiated when the MCO/HH or NYSDOH staff or Interagency Monitoring Team, which is chaired by NYSDOH, identifies a lack in the quality of provided services or any other issue related to administration of waiver services including performance of a contractor or Local/Regional Non-State Entity. If the contract manager, or NYSDOH as a whole, discovers and documents a repeated deficiency in performance of the contractor, MCO or Local/Regional non-State Entity, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of invoiced payment compensation or other actions outlined in each contract. General methods for problem correction include revisions to state contract terms based on lessons learned.

In such situations, the standard procedure is for NYSDOH staff and the Interagency Monitoring Team to discuss the situation and for NYSDOH to issue a statement of deficiency(ies). The contractor, MCO, or Local/Regional Non- State Entity must provide a plan of correction. NYSDOH staff and the IMT may collaboratively work to develop a plan of correction with the contractor, MCO, and/or or Local/Regional Non- State Entities if necessary.
Implementation of and compliance with the plan of correction are monitored by NYSDOH.

If the plan of correction requires a change in the participant's service, NYSDOH staff and the MCO will work cooperatively to address the service deficiency and when necessary, transition the child to another waiver provider. The HH Care Manager (HHCM) will communicate any changes needed to the family and help the family find alternative providers. To ensure continuity of service during the transition period, the original provider will be required to transfer the participant case records and other pertinent documents to the new provider until transition is complete.

If the deficiency also involves a service provider and implementation of the plan of correction does not sufficiently meet

program requirements, the provider may be deemed unfit to continue to provide waiver services. Accordingly, NYSDOH staff will issue a letter to the provider terminating the provider's waiver designation provider status.

After 3/1/2024, the FMS responsible for providing FMS services will identify unsatisfactory vehicle modification, home modification, adaptive and assistive technology, and transitional services (effective 1/1/2026) contractors. The FMS will disqualify unsatisfactory contractors and will find alternate contractors when necessary.

Unsatisfactory accessibility modification, transitional services, and adaptive and assistive technology contractors will be notified of their disqualification from further service by the administering MCO, FMS, or LDSS or DDRO (through transition). The HHCM will help the family find alternate contractors.
Documentation of remediation activities is accomplished by the following measures: correspondence among NYSDOH waiver management staff, MCO, the CM, participants' and their parents/legal guardians, and/or service providers; amended plans of care; case reviews and reports of follow-up meetings with participants and their families documented by MCO and HH; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file.
Circumstances involving remediation are maintained, as appropriate, by NYSDOH and/or the MCO.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance*

with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☒	**Disabled (Physical)**	0	20	
	☒	**Disabled (Other)**	0	20	
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☒	**Brain Injury**	0	20	☐
	☒	**HIV/AIDS**	0	20	☐
	☒	**Medically Fragile**	0	20	☐
	☒	**Technology Dependent**	0	20	☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☒	**Autism**	0	20	☐
	☒	**Developmental Disability**	0	20	☐
	☒	**Intellectual Disability**	0	20	☐
☒ **Mental Illness**					
	☒	**Mental Illness**	18	20	☐
	☒	**Serious Emotional Disturbance**	0	18	

b. Additional Criteria. The state further specifies its target group(s) as follows:

1.Serious Emotional Disturbances (SED) LOC population:
a. Target Criteria
1. Ages 0 to their 21st birthday (including youth ages 18-21 with a mental illness) and

2. The child has a serious emotional disturbance (SED). SED means a child or adolescent has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental disorders (DSM) and has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis, as determined and documented by a licensed mental health professional.

3. SED is defined to include any one of the DSM diagnoses:

a. Schizophrenia Spectrum and Other Psychotic Disorders
b. Bipolar and Related Disorders
c. Depressive Disorders
d. Anxiety Disorders
e. Obsessive-Compulsive and Related Disorders
f. Trauma- and Stressor-Related Disorders
g. Dissociative Disorders
h. Somatic Symptom and Related Disorders
i. Feeding and Eating Disorders
j. Disruptive, Impulse-Control, and Conduct Disorders
k. Personality Disorders
l. Paraphilic Disorders
m. Gender Dysphoria
n. Elimination Disorders
o. Sleep-Wake Disorders
p. Sexual Dysfunctions
q. Medication-Induced Movement Disorders
r. Attention Deficit/Hyperactivity Disorders
s. Tic Disorders

b. Risk Factors – The child meets one of the factors 1–4 as well as factor 5.
1. The child is currently in an out-of-home placement, including psychiatric hospital, or

2. The child has been in an out-of-home placement, including psychiatric hospital within the past six months, or

3. The child has applied for an out-of-home placement, including placement in psychiatric hospital within the past six months, or

4. The child currently is multi-system involved (i.e., two or more systems) and needs complex services/supports to remain successful in the
community.

5. A licensed practitioner of the healing arts (LPHA), who has the ability to diagnose within his/her scope of practice under State law or who is under the supervision of another licensed practitioner of the healing arts who has the ability to diagnose within his/her scope of practice under State law, has determined in writing, that the child, in the absence of HCBS is at risk of institutionalization (i.e., hospitalization). The LPHA has submitted written clinical documentation to support the determination.

Out of-home placement in LOC Risk Factor #1–4 includes: RRSY, RTF, RTC, or other congregate care setting, such as SUD residential treatment facilities, group residences, institutions in the OCFS system or hospitalization.

Multi-systems involved means two or more child-serving systems, one of which must be involvement in the children's mental health system and at least one other system. If the member is receiving more than one mental health service (CFTSS, clinic, etc.), this would only count as one system involvement, inclusive of the school-based behavioral health services. Other systems can include child welfare (e.g., CPS, Foster care), juvenile justice (e.g., Probation), Department of Homeless Services, OASAS clinics or residential treatment facilities or institutions, OPWDD services or residential

facilities or institutions, or having an established IEP, 504 plan, and in receipt of services through the school district.

2. Medically Fragile LOC population:
a. Target Criteria
1. Ages 0 to their 21st birthday Note: MF children may optionally transition to MLTC on their 18th birthday.

2. The child must have a documented physical disability following state demonstration protocols.
i. Current SSI Certification or
ii. DOH-5144 or
iii. HCBS LOC Determinations the Forms: OHIP 5151, OHIP 5152 and OHIP 5153 completed by appropriate professionals and caregivers to be reviewed and approved by an LPHA

3. Developmental Disability LOC population who are Medically Fragile:
a. Target Criteria

1. Ages 0 to their 21st birthday
2. Medically Fragile as defined by subset of questions from CANS-NY Algorithm
3. Child has developmental disability as defined by OPWDD which meets one of the criteria a–c as well as criteria d and e
a. Is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism, or
b. Is attributable to any other condition of a child found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior of a child with intellectual disability or requires treatment and services similar to those required for such children, or
c. Is attributable to dyslexia resulting from a disability described above; and originates before such child attains age 22; and
d. Has continued or can be expected to continue indefinitely; and
e. Constitutes a substantial handicap to such child’s ability to function normally in society.

4. Developmental Disability LOC population who are in or were formerly in Foster Care:
a. Target Criteria
1. Ages 0 to their 21st birthday

2. Child has developmental disability as defined by OPWDD which meets one of the criteria a–c as well as criteria d and e.
a. Is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism, or
b. Is attributable to any other condition of a child found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior of a child with intellectual disability or requires treatment and services similar to those required for such children, or
c. Is attributable to dyslexia resulting from a disability described above; and originates before such child attains age 22; and
d. Has continued or can be expected to continue indefinitely; and
e. Constitutes a substantial handicap to such child’s ability to function normally in society.

b. Risk Factor
1. The child must be either: 1) a current FC child in the care and custody of Local Departments of Social Services (counties and New York City) (LDSS) or a child in the custody of OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY) or 2) a FC child who enrolled in HCBS originally while in the care and custody of Local Departments of Social Services (counties and New York City) (LDSS) or a child in the custody of OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY). Once enrolled, eligibility continues so long as the child continues to meet targeting and functional criteria (no break in coverage permitted) and requires an HCBS on their Plan of Care to avoid institutionalization up to their 21st birthday.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to

individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- ○ **Not applicable. There is no maximum age limit**
- ◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Eligibility for Children's Waiver ends on the day of the waiver participant's twenty-first birthday. As physically disabled participants reach their seventeenth (17) birthday, the HH will begin to assist the enrollees in planning for transition to other services and/or programs. Waiver enrollees with physical disabilities who reach their eighteenth (18) birthday may transition to Medicaid managed care or to another HCBS waiver that serves adults, such as the Nursing Home Transition and Diversion (NHTD) waiver or the Traumatic Brain Injury (TBI) waiver, as available and/or appropriate. It should be noted that the Children's waiver allows these children to continue receiving waiver services until their 21st birthday, if needed.

For Foster Care and SED enrollees, eighteen months prior to reaching the enrolled child's 21st birthday, the Health Home generates a Transition Plan that identifies the action steps needed to connect with services each child needs in adulthood and the party responsible for conducting the action steps. This Transition Plan outlines the ongoing Medicaid State Plan and waiver services that may be accessed from another Home and Community Based Services (HCBS) authority that offers appropriate services. This Transition Plan requires an evaluation of the participant for adult services. An essential component of transition planning is verifying that all necessary eligibility and/or assessment information is current and accurate to facilitate the child's transition from the waiver to appropriate adult services. It should be noted that the waiver allows these children to continue receiving waiver services until their 21st birthday, if needed.

The Children's Waiver package of services is not comparable to the adult system because their needs differ significantly. Waiver participants are eligible to receive all services until they are discharged from the waiver. The POC for youth over age 14 must include goals developing a participant's capacity to live independently and the identification of available resources. When the youth transitions from the waiver, the HH in collaboration with the MCO (for managed care enrollees) will be responsible for preparing a POC and making referrals, which will assist in transitioning the participant to adult services and resources.

The POC and necessary referrals to adult services is used by the MCO/HH to document follow-up needed and for future MCO care coordinators (MCOCC) or HHCM with continuing responsibility following discharge from the HCBS waiver to ascertain that discharge services are implemented, and if not, what actions need to be taken.

The MCOCC or HHCM is responsible for all documentation and for coordinating services following a child's departure from the HCBS waiver. The MCOCC or HHCM intervenes as appropriate if problems are noted and continues documenting in the POC.

If the child continues to meet the targeting, risk and LOC determination under the 1915(c) Children's waiver and requests a service on the 1915(c) Children's waiver that is not on one of the adult waivers such as the Nursing Home Transition and Diversion (NHTD) waiver or the Traumatic Brain Injury (TBI) waiver, the child will be permitted to remain on the Children's waiver up to their 21st birthday. A transition plan will be developed to transition this child to the adult waivers.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◉ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	17379
Year 2	

Waiver Year	Unduplicated Number of Participants
	17379
Year 3	17379
Year 4	17379
Year 5	17379

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	13894
Year 2	13894
Year 3	13894
Year 4	13894
Year 5	13894

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The state *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
Children in child welfare with DD	
Children who are medically fragile	
Children who are medically fragile and developmentally disabled	
Mental Health Crisis Slots	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Children in child welfare with DD

Purpose *(describe):*

The State is reserving capacity to ensure that children in child welfare with DD will have access if there is ever a waiting list.

As of 12/20/2021, there is no wait-list. There are 5,551 children on the waiver and 8,343 available slots.

Describe how the amount of reserved capacity was determined:

The methodology uses former B2H DD slots and projects forward to ensure that there is not a surplus of unused capacity among the regions. There will be no wait list for children in child welfare with DD.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	541
Year 2	541
Year 3	541
Year 4	541
Year 5	541

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Children who are medically fragile

Purpose *(describe):*

The State is reserving capacity to ensure that children with medical fragility will have access to the waiver if there is ever a waiting list.

As of 12/20/2021, there is no wait-list. There are 5,551 children on the waiver and 8,343 available slots.

Describe how the amount of reserved capacity was determined:

The methodology uses former B2H MF and CAH I/II slots and projects forward to ensure that there is not a surplus of unused capacity among the regions. There will be no wait list for Medically Fragile children.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	1900
Year 2	1900
Year 3	1900
Year 4	1900
Year 5	1900

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Children who are medically fragile and developmentally disabled

Purpose *(describe):*

The State is reserving capacity to ensure that children who are medically fragile and developmentally disabled have access to the waiver even if there is a wait list.

As of 12/20/2021, there is no wait-list. There are 5,551 children on the waiver and 8,343 available slots.

Describe how the amount of reserved capacity was determined:

The methodology uses former CAH MF/DD slots and projects forward to ensure that there is not a surplus of unused capacity among the regions. There will be no wait list for Medically Fragile children.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	520
Year 2	520
Year 3	520
Year 4	520
Year 5	520

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Mental Health Crisis Slots

Purpose *(describe):*

The State is reserving capacity to ensure that children with mental health in crisis have access to the waiver if there is ever a waiting list.

As of 12/20/2021, there is no wait-list. There are 5,551 children on the waiver and 8,343 available slots.

Describe how the amount of reserved capacity was determined:

The methodology uses 10% of the capacity of the former SED waivers and projects forward the expected growth to ensure that there is not a surplus of unused capacity among the regions.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	464
Year 2	464
Year 3	464

Waiver Year	Capacity Reserved
Year 4	464
Year 5	464

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ○ **Waiver capacity is allocated/managed on a statewide basis.**
- ◉ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

The waiver capacity is allocated/managed on a statewide basis by NYSDOH. The slots are not allocated to any local/regional non-state entity. The State will use 5 regional targets to ensure that all regions have equitable access to children's HCBS. The methodology uses historical utilization, projects forward the expected growth in the number of new 1915(c) slots and reevaluates the methodology on an annual basis or as needed to ensure that there is not a surplus of unused capacity among the regions. There will be no wait list for Medically Fragile children. There is no wait-list for this waiver as of 12/15/2021 for any population.

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The Children's waiver provides enrollment for eligible children who must be under 21 years of age, require the level of care provided in a nursing facility, ICF/IID or hospital, and be capable of being cared for in the community if provided with HCBS under this waiver.

Enrollment is based on first come first served if there is no waiting list. If no Waiver slots are available, all children will be placed on a wait list. While on the wait list, the Community eligible Medicaid applicant's needs are managed through other services until there is an opening in the waiver. Once referred to Health Home, the Health Home is responsible for ensuring that the child is eligible under the Waiver. If a child is in crisis and waiver services would divert an institutionalization or waiver services would reduce the length of a current institutionalization, then the child is eligible for a reserved crisis waiver slot based upon notification of the availability of a crisis slot from NYSDOH. NYSDOH will manage the wait list for any Family of One child who cannot receive Medicaid services until there is a waiver slot for the child.

As of 12/15/2021, there is no wait-list for the waiver or Health Homes. It is not anticipated that Health Homes will have a wait-list.

Total Enrollment (filled) as of January 2, 2020 - 6,737
Total Number of Currently Available Slots - 2,004

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **Section 1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR § 435.217)

- [ ] **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- [ ] **Pregnant Women (42 CFR § 435.116)**
- [ ] **Infants and Children under Age 19 (42 CFR § 435.118)**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- [x] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act)**

☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)**

☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in section 1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR § 435.330)**

☒ **Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Infants and children under Age 19 (42 CFR 435.117 and 42 CFR 435.118);
Pregnant Women (42 CFR 435.116);
Mandatory Coverage of Parents and other Caretaker Relatives (42 CFR 435.110);
Optional Coverage of Parents and other Caretaker Relatives with Medicare (42 CFR 435.220);
Adult Group (coverage non-pregnant individuals age 19-64, not enrolled in Medicare) (42 CFR 435.119); Children who qualify for State adoption assistance (42 CFR 435.227);
Children for whom an adoption agreement is in effect or foster care maintenance payments are being made under Title IV-E, including Children with adoption assistance, foster care, or guardianship care under title IV-E, (42 CFR 435.145);
Individuals who qualify under 1902(a)(10)(A)(i)(II)(bb)(Qualified Severely Impaired); and
Disabled Adult Children (DAC) beneficiaries who are eligible under 1634c of the Social Security Act; Medically needy children under age 21 (42 CFR 435.308);
SSI-related medically needy children with a waiver of 1902(a)(10)(C)(i)(III) meeting institutional LOC.

Special home and community-based waiver group under 42 CFR § 435.217) *Note: When the special home and community-based waiver group under 42 CFR § 435.217 is included, Appendix B-5 must be completed*

◉ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.** *Appendix B-5 is not submitted.*

○ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR § 435.217**

○ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR § 435.217**

Check each that applies:

☐ **A special income level equal to:**

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR § 435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR § 441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR § 435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR § 435.217:

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under section 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State ? January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR § 441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- (●) **Other**

Specify:

All LOC evaluations and reevaluations are completed by a NYS Health Home, the State's staff or the DDRO. Evaluations for children/youth with SED may also be completed by New York State Mental Health Single Points of Access (SPOAs).

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR § 441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The evaluation of level of care for Children's waiver applicants is performed by a Care Manager in the State of New York in a Health Home or state staff (for Hospital or Nursing Facility LOC) or a Developmental Disabilities Regional Office staff person (for ICF/IID LOC). Evaluations for children with SED may also be completed by New York State Mental Health Single Points of Access (SPOAs).

In order to be a CANS-NY assessor (for NF and hospital LOC) for the Health Home, State staff, or DDRO, a Health Home Care Manager (HHCM), state staff, or SPOA evaluator must attend a training (online or in-person) and complete a certification exam with a minimum reliability score of 0.70 (online).

In addition, a HHCM must have the experience required to meet the care planning needs of the child as determined by, but not limited to, acuity (as measured by the CANS-NY, and/or the children's overall needs), presence of a single qualifying or co-occurring conditions, including Serious Emotional Disturbance, Complex Trauma, co-occurring medical or co-morbid conditions. Staff qualifications for care managers that serve children with an acuity level of "high" as determined by the CANS-NY are:
• A Bachelors of Arts or Science with two years of relevant experience, or
• A License as a Registered Nurse with two years of relevant experience, or
• A Masters with one year of relevant experience.

For children with a high acuity that are enrolled in the Early Intervention Program and receiving Health Home services through a provider approved under the Early Intervention Program, the minimum qualifications for EIP service coordinators set forth in Section 69-4.4 of 10 NYCRR will apply. Those qualifications are a minimum of one of the following educational or service coordination experience credentials:
i. two years of experience in service coordination activities as delineated in this Subpart (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or
ii. one year of service coordination experience and an additional year of experience in a service setting with infants and toddlers with developmental delays or disabilities; or
iii. one year of service coordination experience and an Associates degree in a health or human service field; or
iv. a Bachelors degree in a health or human service field. Demonstrated knowledge and understanding in the following areas:
i. infants and toddlers who may be eligible for early intervention services;
ii. State and federal laws and regulations pertaining to the Early Intervention Program;
iii. principles of family centered services;
iv. the nature and scope of services available under the Early Intervention Program and the system of payments for services in the State; and
v. other pertinent information.

In order to be an I/DD LOC assessor, the qualified professional with at least one year of experience in conducting assessments or developing plans of care for people with developmental disabilities. Initial LOCs are reviewed by a physician and include the assessments conducted by "qualified practitioners" who may administer and interpret standardized measures of intelligence and adaptive behavior. A qualified professional is a person with a directly relevant master's degree or doctoral level education in psychology, who has training and supervised experience in the use and interpretation of such measures consistent with the recommendations contained in the respective test manuals for measures and with the requirements of ERA/APA/NCME (1999) standards for test administration and use and interpretation of individual test results.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency

(if applicable), including the instrument/tool utilized.

Certain Level of Care criteria are used to evaluate whether an applicant/participant requires and/or continues to require Children's waiver services. The applicant/participant must be under the age of 21; and require either a skilled nursing facility, ICF-IID or hospital level of care.

The UAS-NY is a secure system accessed through Health Commerce System (HCS) web portal. It contains the CANS-NY assessment HCBS eligibility algorithm used to determine functional criteria for NF and Hospital LOC, as well as eligibility information for the ICF/IID LOC determination.

The HHCM and SPOA has the responsibility for completion of initial Level of Care determinations and Annual Level of Care recertifications, as well as any periodic LOC recertifications. If the applicant is not yet Medicaid eligible, a state staff member will complete the initial level of care determination. A subset of the assessment instrument, the CANS- NY is performed at least annually and as needed when significant changes occur in the child's life for the determination of NF and Hospital Level of Care (LOC). The Developmental Disability Regional Office (DDRO) will have UAS-NY eligibility access to complete the ICF/IID LOC for children requiring that LOC initially as well as for the annual redetermination. The DDRO will refer the child back to the HH for the plan of care development.

The LOC determination for the Waiver is made based on the following: 1. the child meets the clinical eligibility criteria, 2. the Waiver candidate must be capable of being cared for in the community if provided access to appropriate waiver and state plan services. If the aforementioned criteria for the waiver are not met by applicant, the applicant's needs are managed through other services, including possible institutional placement in a hospital, nursing facility or ICF/IID.

CANS-NY HCBS eligibility algorithm is based on a subset of the CANS-NY questions or items and has been used for assessing individual improvement, identification of service needs, determination of NF and Hospital level of care, treatment planning, assessing the quality of services, and providing feedback regarding system functioning. CANS-NY also helps guide choices about treatment type, intensity and progress by the child to monitored continuous appropriateness of services based on the LOC determination.

The ICF/IID level of care instrument for the HCBS Waiver is identical to the level of care instrument used for ICF/DD. The same instrument is used for both initial evaluations and re-certifications. A paper copy of the level of care instrument has been submitted in the Comprehensive 1915(c) waiver and is available from OPWDD for CMS' review upon request. The level of care instrument and instructions are available on the OPWDD website at the following location: https://opwdd.ny.gov/providers/coordinated-assessment-system-cas. The level of care instrument does not limit participation by individuals with certain conditions or diagnoses. Decisions about ICF/IID eligibility are also documented in the Health Commerce System (HCS).
The criteria appearing in the level of care instrument are:
1. Evidence of a developmental disability,
2. Disability manifested before age 22,
3. Evidence of a severe behavior problem (not required),
4. Health care need (not required),
5. Adaptive behavior deficit in one or more of the following areas: communication, learning, mobility, independent living or self-direction.

The applicant must have functional limitations that demonstrate a substantial handicap. For most applicants over the age of eight, the substantial handicap must be determined using a nationally normed and validated, comprehensive measure of adaptive behavior, administered by a qualified professional. For applicants over the age of eight who have an IQ of 60 or lower, the presence of a substantial handicap may be assessed and confirmed through clinical observation or interview rather than standardized testing.

For children (birth through eight) with a developmental delay, but no specific diagnosis, provisional eligibility may be confirmed based on clinical judgment by use of criteria based on 20 CFR, Appendix 1 to Subpart P of Part 404 regarding SSI eligibility, and determination of functional limitations in motor development, cognition and communication or social function. Consistent with Section 200.1 (mm)(1) of NYS Education Department regulations, substantial handicap associated with delay can be documented by the results of an evaluation that indicates:
- A 12-month delay in one or more functional areas, or
- A 33% delay in one functional area, or a 25% delay in each of two functional areas; or
- If appropriate, standardized instruments are administered yielding a score of 2.0 deviations below mean in one functional area or a score of 1.5 standard deviations below the mean in each of two functional areas.

Additional information on this ICF-IID process is contained within OPWDD policy guidance. Any future changes to this process/requirements will be contained within OPWDD policy guidance

e. Level of Care Instrument(s). Per 42 CFR § 441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The CANS-NY eligibility algorithm for NF and hospital LOC based on a subset of the CANS-NY assessment or the ICF/IID tool will be used to determine level of care for initial and annual redeterminations. The ICF/IID LOC tool is the same as the instrument used to determine ICF/IID institutional care. The CANS-NY tool has been validated against the criteria used for admission to hospitals and nursing facilities by the CANS-NY Technical Assistance Institute and found to be reliable, valid and fully comparable. For more information see: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/cansny.htm

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR § 441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The information collected for eligibility, at a minimum, includes: family background, diagnosis, a complete description of the child's medical and behavioral health condition, type and frequency of needed medical/clinical interventions, developmental level of the child, and any other medical or social information pertinent to the child in order to determine and document the level of care at which the child is assessed.

If the HHCM, state staff, or SPOA needs additional information to complete the eligibility evaluation, he/she may directly request the information from the parent, child if appropriate, or the child's physician and other family-involved professionals. The Children's waiver will utilize the CANS- NY or ICF/IID to determine a potential waiver participant's initial level of care and his/her annual LOC re- evaluations. The assessment will be completed only by individuals who have successfully completed the training in the use of CANS- NY (or DDRO trained individuals in the ICF-IID tool) and only those individuals will be able to access the web based technology of the UAS-NY, which houses the CANS-NY and ICF-IID eligibility information.

The eligibility evaluation presents care options for the individual and identifies persons who are nursing home, ICF/IID, or hospital level of care eligible. Assessors are required to use their professional judgment to determine the appropriate program options for the individual.

The web based eligibility evaluation will be made available to the HHCM and MCO (if applicable). If there appears to be any question regarding the applicant's nursing home or hospital level of care, the selected HHCM will consult with the NYSDOH to resolve any identified issues. The DDRO will consult with OPWDD and NYSDOH regarding any ICF-IID questions.

As part of the annual POC review, the HHCM reviews the Eligibility Evaluation to confirm that the applicant meets the LOC criteria for waiver participation; confirms Medicaid eligibility; reviews recent documentation to support a functional eligibility; and confirms the age of the applicant.

The HH is responsible for assuring that the initial and annual LOC assessments are completed by qualified evaluators and in a manner timely to waiver participation. The SPOA may conduct the evaluations for SED children. NYSDOH staff are able to access the UAS-NY through the Health Commerce System for review.

The Health Commerce System (HCS) is the NYS Department of Health's web portal. HCS is a secure, private network designed for sharing health-related information with health organizations throughout New York State. The HCS meets all of the requirements of HIPAA and HITECH, as well as other New York State laws. It contains the UAS-NY for LOC determinations as well as the MAPP-HHTS for Health Home outreach and enrollment.

Initial level of care evaluations must be completed prior to the approved enrollment date for community based individuals. Family of One eligibles must have an initial level of care evaluation, plan of care and financial eligibility completed prior to enrollment in the HCBS waiver and Medicaid. Enrolled waiver participants are reevaluated annually in conjunction with the POC review or at any time the participant experiences a significant change of condition.

g. Reevaluation Schedule. Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR § 441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

In accordance with program guidelines, the HHCM are required to assist the participant/family in understanding, meeting and completing necessary program requirements, such as the annual level of care re-evaluation.

Each HHCM maintains an automated report which indicates when each participant's annual level of care re- evaluation is due. This is usually part of a larger re-evaluation package which may include Medicaid eligibility and medical documentation, physician orders and plan of care review. A change in the participant's medical condition or home situation could also necessitate a re-evaluation.

A HHCM or DDRO staff member authorized to implement the eligibility evaluation, completes the eligibility evaluation on an annual basis or whenever there is a change in the enrollee's medical status. The re-evaluation documentation indicates the findings of the evaluation and is included in the UAS system.

As part of his or her role for oversight of children enrolled in the waiver, the HHCM maintains regular contact with the MCO (for children enrolled in managed care) or NYSDOH staff (for FFS children) to discuss the progress of each enrollee, identify needs, and solve problems.

NYSDOH staff, the Interagency Monitoring Team, HHCM, and the MCO review the reports at least quarterly to ensure that the annual level of care and other documentation that comprises the re-evaluation package was completed in a timely manner.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR § 441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The HHCM must retain the letter of notification, level of care determinations, home assessments, plans of care and all other information pertaining to the child's enrollment and continued eligibility for the waiver in the waiver applicant's file. For children for whom they have conducted an eligibility evaluation, the state staff member or SPOA retains the letter of notification, level of care determination and information pertaining to the child's enrollment. This information must be retained for the duration of the child's enrollment in the waiver and for at least six years after the child's 21st birthday for possible post-audit and evaluation by either state or federal agents.

A copy of the initial evaluation of the waiver applicant is kept on file in the UAS system.

The UAS-NY is a web-based application. All eligibility evaluation information is entered directly into and stored in the web-based application. The eligibility evaluation information is stored on a secure server for the CANS-NY eligibility algorithm. The DDRO maintains a copy of any information not contained in the UAS-NY system for ICF-IID determinations.

The HHCM or DDRO is the primary person to arrange for the annual LOC reassessment by a certified assessor. The HH is responsible to maintain a system for tracking the annual LOC re-assessment due date. Any printed LOC assessments must be stored in a secure locked location.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of applicants where there is an evaluation for LOC provided if there is a reasonable indication that services may be needed (N Number of applicants where there is an evaluation for LOC provided if there is a reasonable indication that services may be needed/ D Total number of all applicants)

Data Source (Select one):
Other
If 'Other' is selected, specify:
UAS-NY HCBS LOC Determinations; FFS Claim & MC Encounter Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants reviewed where the LOC processes and instruments were completed as required in the approved waiver (N number of participants reviewed where the LOC processes and instruments were completed as required in the approved waiver / D total participants reviewed)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% CI +/- 5% margin of error
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

A statistically significant random sample of waiver cases (95% confidence level with a +/- 5% margin of error) are randomly selected for review by NYSDOH or its designee. The materials reviewed include the child's assessments, physician orders, case management plans, and claim detail reports. Documents are reviewed for proper signatures and dates, timely completion, follow-through on the medical plan and overall plan of care and utilization of services. Care management notes are also reviewed in order to substantiate billings and subsequent Medicaid reimbursement.

Tracking reports:
The State has developed a Children's Waiver performance matrix that tracks and gather data/reports from other entities on a quarterly and annual basis. The State IMT reviews these reports and information to determine interventions. Health Homes receive a summary of findings from annual reviews and the State follow up regarding corrective action plans.

Conference calls:
Regular conference calls enable the sharing and peer discussion of HCBS issues between the State staff, MCOS, and HH.

NYSDOH staff may also present new directives or waiver topics.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The remediation process is initiated when the MCO/HH or SPOA or NYSDOH staff or Interagency Monitoring Team identifies a lack in the quality of provided services or any other issue related to administration of waiver services including an issue with a Level of Care determination. During the annual case reviews, NYSDOH or its designee performs quality reviews of initial and annual level of care determinations to ensure that the proper criteria are applied, the LOC determinations and redeterminations are made timely, and the processes and forms outlined in the waiver were utilized correctly. In instances when it is discovered that this has not occurred the team recommends that the SPOA, HHCM or state staff take steps to initiate a new level of care determination. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

In such situations, the standard procedure is for NYSDOH staff, MCO, and Interagency Monitoring Team to discuss the situation and for NYSDOH to issue a statement of deficiency(ies). The SPOA or HH must provide a plan of correction. NYSDOH staff, MCO, and the IMT may collaboratively work with the SPOA or HH to develop a plan of correction, if necessary. Implementation of and compliance with the plan of correction are monitored by NYSDOH and the MCO.

If the plan of correction requires a change in the participant’s service, NYSDOH staff and the MCO will work cooperatively to address the service deficiency and when necessary, transition the child to another waiver provider. The HHCM will communicate any changes needed to the family and help the family find alternative providers. To ensure continuity of service during the transition period, the original provider will be required to transfer the participant case records and other pertinent documents to the new provider until transition is complete.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide waiver services. The provider may be referred to the licensure or certification agency staff, as needed. Accordingly, NYSDOH staff, or its designee the IMT, will issue a letter to the provider terminating the provider’s waiver designation provider status.

Unsatisfactory accessibility modification and adaptive and assistive technology contractors will be notified of their disqualification from further service by the administering MCO, FMS, DDRO or LDSS (through the transition). The HHCM will help the family find alternate contractors.
-After 3/1/2024, the FMS responsible for providing FMS services will identify unsatisfactory vehicle modification, home modification, adaptive and assistive technology, transitional services (effective 1/1/2026), and Goods and services contractors. The FMS will disqualify unsatisfactory contractors and will find alternate contractors when necessary.

Documentation of remediation activities is accomplished by the following measures: correspondence among NYSDOH waiver management staff, MCO, the CM, participants’ and their parents/legal guardians, and/or service providers; amended plans of care; case reviews and reports of follow-up meetings with participants and their families documented by MCO and HH; and the results of NYSDOH annual reviews. All such documents are maintained in the participant’s case file. Circumstances involving remediation are maintained, as appropriate, by NYSDOH and/or the MCO.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency Designee (NYSTEC)	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR § 441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

At the time of application for enrollment in the waiver, the HHCM ensures that eligible individuals have been informed of feasible alternatives of care and informing the individual, or their legal representative, about their freedom of choice between waiver and institutional services. If the SPOA or state staff determined initial eligibility, then the HHCM will ensure that these steps are performed. Individuals who are 18 years of age, parents, pregnant, and/or married, and who are otherwise capable of consenting, may exercise independent choice of enrollment in waiver and provider or to disenroll from the HH during the HCBS enrollment process and each annual reevaluation or at anytime the individual/family contacts the Health Home. The applicant, applicant's parents/ guardians/ legally authorized representative are required to sign the Freedom of Choice form indicating their decision whether or not to have their child receive services under the Medicaid waiver. This form must be witnessed and dated; it is kept as part of the applicant's permanent case file at the HH.

Individuals who are 18 years of age, parents, pregnant, and/or married, and who are otherwise capable of consenting, may exercise independent choice of enrollment in waiver and provider or to disenroll from the HH during the HCBS enrollment process and each annual reevaluation or at anytime the individual/family contacts the Health Home. The applicant/parents/legal guardians also sign the Choice of Case Management/Provider Selection form, indicating their choice of HHCM and HCBS waiver providers for their child.
Each HH has a list of available waiver providers that is shared with the participants and their parent(s)/legal guardians including the HCBS providers available in each MCO. A copy of each of these forms is given to the parent, and maintained in HH.

b. Maintenance of Forms. Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Freedom of Choice form and Choice of Care Management/Provider Selection form are kept on file at the HH in the applicants' case files.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Persons with limited fluency in the English language must be able to apply for benefits without undue hardship. The HH must have arrangements to provide interpretation or translation services for a person who will need them. Non-English speaking applicants may bring a translator of their choice with them to the HH. However, applicants cannot be required to bring their own translator, and no person can be denied access on the basis of HH's inability to provide adequate translations. [NYS DOH GIS 99 MA/021 and 95 INF-15] All HH are required to contract with telephone translation/interpretation services for applicants with limited English proficiency.

The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). Appendix B describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

Further, on October 6, 2011, NYS Governor Cuomo signed Executive Order (EO) # 26, “Statewide Language Access Policy” requiring State agencies, that provide direct public services, to offer free language access services to limited English proficient members of the public. Accordingly, statewide interpretation and translation contracts are in place to assist waiver applicants and participants.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case*

management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Community Habilitation		
Statutory Service	Day Habilitation		
Statutory Service	Prevocational Services		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Other Service	Adaptive and Assistive Technology		
Other Service	Caregiver/Family Advocacy and Support Services		
Other Service	Environmental Modifications		
Other Service	Financial Management Services		
Other Service	Non-Medical Transportation		
Other Service	Palliative care - Expressive Therapy		
Other Service	Palliative care – Counseling and Support Service		
Other Service	Palliative care – Massage Therapy		
Other Service	Palliative care – Pain and Symptom Management		
Other Service	Transitional Care Coordination		
Other Service	Transitional Services		
Other Service	Vehicle Modifications		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Community Habilitation

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Community Habilitation covers in person services and supports related to the child's acquisition, maintenance and enhancement of skills necessary to perform Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) and/or Health-Related Tasks delivered in the community (non-certified) settings.
Acquisition, maintenance and enhancement are defined as:

Acquisition is described as the service available to a child who is seeking greater independence by learning to perform the task for him or herself. There should be a reasonable expectation that the individual will acquire the skills necessary to perform that task.
Maintenance is described as the service available to prevent regression in the child's skill level and to also prevent loss of skills necessary to accomplish the identified task.
Enhancement activities are provided to the child through training and demonstration to promote growth and independence with an already acquired skill level and to support the child's goal outside of the training environment.

ADL, IADL, skill acquisition, maintenance and enhancement are in person services that are determined by the person-centered planning process and must be identified in the child's plan of care (POC) on an individual or group basis. These identified services will be used as a means to maximize personal independence and integration in the community, preserve functioning and prevent the likelihood of future institutional placement. For this reason, skill acquisition, maintenance and enhancement services are appropriate for children who have the capacity to learn to live in the community, with or without support. Community Habilitation may be delivered in individual or group modality.

ADL, IADL skill acquisition, maintenance and enhancement is related to assistance with functional skills and may help a child who has difficulties with these types of skills accomplish tasks related to, but not limited to:

Self-care Life safety
Medication and health management
Communication skills
Mobility
Community transportation skills
Community integration
Appropriate social behaviors
Problem solving
Money management

Provider and Condition Requirements

ADL, IADL, skill acquisition, maintenance and enhancement will be performed by a direct care worker, who shall include personal care aides; personal attendants; certified home health aides; direct service professionals who meet the licensure and certification requirements under NYCRR Title 18; or providers approved through the Office for People With Developmental Disabilities (OPWDD) to provide Community Habilitation

ADL, IADL skill acquisition, maintenance and enhancement must be provided under the following conditions:

The need for skills training or maintenance activities has been assessed, determined and authorized as part of the person-centered planning process;

o Provider agencies of Community Habilitation must develop a Habilitation service plan to document the child's goal(s)/outcome(s), health and safety needs required during the delivery of the service, and the necessary staff actions to assist the child reach his/her Community Habilitation goal(s)/outcome(s), and health/safety needs.
The activities are for the sole benefit of the child and are only provided to the child receiving home and community-based services or to the family/caregiver in support of the child;
The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the child has a progressive medical condition.
The activities provided are consistent with the child's stated preferences and outcomes in the plan of care (POC);
The activities provided are coordinated with the performance of ADLs, IADLs and health related tasks;
Training for skill acquisition, maintenance and enhancement activities that involve the management of behaviors must use positive enforcement techniques; and
The provider is authorized to perform these services for HCBS recipients and has met any required training, certification

and/or licensure requirements.

Some specific ADL services available for training includes, but is not limited to: Bathing/personal hygiene; dressing; eating; mobility (ambulation and transferring); and toileting.

Some specific IADL services available for skills training includes, but is not limited to:
Managing finances; assisting with transportation (as indicated in the POC); shopping for food, clothes and other essentials; preparing meals; assisting with the use of the telephone and/or other communication devices; managing medications; light housekeeping; environmental maintenance such as maintaining safe egress; and laundry.
If the POC indicates that learning how to navigate travel from one location in the community to another is a goal for the child, this service will include the assistance provided by a direct care worker to accompany the child while learning the skill. The in person service time when a direct care worker is assisting or providing transportation to an individual may also be billed as part of the Community Habilitation service.

Community Habilitation includes activities to support the acquisition of skills related to ADL, IADL, and personal health-related tasks. The simple provision of the ADL, IADL, and health-related tasks by the staff provider is not an allowable service component (i.e., staff can help the participant learn how to prepare foods/supplements to support the member's complex dietary needs, but should not be independently preparing these foods/supplements on their own). Health-related tasks are defined as specific tasks related to the needs of a child, which can be delegated or assigned by licensed health-care professionals under State law to be performed by a certified home health aide or a direct service professional. Health related tasks also include tasks that home health aides or a direct service professional can perform under applicable exemptions from the Nurse Practice Act.

Some specific health-related tasks available for assistance includes, but is 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 medications; assisting with the use of medical equipment, supplies and devices; assisting with special skin care; assisting with a dressing change; and assisting with ostomy care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

These services can be delivered at any Office for People with Developmental Disabilities (OPWDD) certified community habilitation agency, which has been designated through the NYS Children’s Provider Designation Review Team. Such a setting might include the child’s home which may be owned or rented, and work setting. Please note that this service cannot be substituted for vocational rehabilitation services provided under the Rehabilitation Act of 1973 or other Children’s HCBS. Approved settings do not include an OPWDD certified residence, congregate or institutional settings, a social day care or health care setting in which employees of the particular setting care for or oversee the child. Foster care children meeting LOC may receive these services in a home or community-based setting where they reside that is not an institution. OCFS Licensed Institutions are defined in New York State Social Services law section 427.2(f) as a facility established for the 24-hour care and maintenance of 13 or more children and operated by a childcare agency (Voluntary Foster Care Agency).

Children living in certified settings may only receive this service on weekdays with a start time prior to 3 pm. For school-age children, this service cannot be provided during the school day when a child is participating or enrolled in a school program.

Time spent receiving another Medicaid service cannot be counted toward the Habilitation billable service time. This service cannot be delivered nor billed while a child is in an ineligible setting, such as in a hospital, ICF/IID or skilled nursing facility.

Community Habilitation services provided under this waiver cannot be duplicative or delivered at the same time as services otherwise available to a child through a local educational agency including those services available under the Please note: It is the responsibility of the HCBS agency to ensure that staff providing services have adequate training and knowledge to address the individual child/youth’s needs (including but not limited to physical and/ or medical needs such as medications or technology).

It is the responsibility of the Care Manager to ensure that the HCBS providers developed service plan sufficiently outlines how the service being provided will address the participant’s needs reach desired goals, and that the established Frequency/Scope/Duration is appropriate meeting all HCBS requirements to address the individual child/youth’s needs (including but not limited to physical and/or medical needs such as medications or technology),
OR have made arrangements for an appropriately trained and knowledgeable individual to address the individual

child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology Individuals with Disabilities Education Act (IDEA) or Rehabilitation Act of 1973. Staffing ratios cannot exceed 1:4 staff to consumers.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Habilitation Agency providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Habilitation

Provider Category:

Agency

Provider Type:

Community Habilitation Agency providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Certified by the Office for People with Developmental Disabilities (OPWDD) to provide community habilitation. Providers must have appropriate license, certification and/or approval in accordance with State requirements. Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum. Direct service workers must have background checks. Direct service workers and supervisory staff must have at least a high-school diploma or its equivalent education.

Training must include:

• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.

• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines

• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service sunsets on January 1, 2026. Service provision will be delivered through Community Habilitation without the restriction of services to be provided in an OPWDD setting.

Assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills including communication, and travel that regularly takes place in a non-residential setting, separate from the person's private residence or other residential arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy and informed choice. Day Habilitation (DH) services are provided to a child at a NYS certified (e.g., OPWDD certified) setting typically between the daytime hours of 9am-3pm. However, service delivery may include outings to community (non-certified) settings.

Individual Day Habilitation (a one-to-one, individual-to-worker provided service with an hourly unit of service) and Group Day Habilitation services are furnished 4 or more hours per day on a regularly scheduled basis for 1 or more days per week or less frequently as specified in the participant's POC. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

A supplemental version of Individual and Group Day Habilitation is available for children who do not reside in a certified setting. The supplemental Day Habilitation is provided outside the 9am-3pm weekday time period, and includes later afternoon, evenings, and weekends. Day Habilitation and Supplemental Day Habilitation services cannot be delivered at the same time.

All Day Habilitation services (Group and individual) have the same service description and focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational or speech therapies in the POC. In addition, Day Habilitation services may serve to reinforce skills, behaviors or lessons taught in other settings. Provider agencies of Day Habilitation must develop a Habilitation service plan to document the child’s goal(s)/outcome(s), health and safety needs required during the delivery of the service, and the necessary staff actions to assist the child reach his/her Day Habilitation goal(s)/outcome(s), and health/safety needs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Group and individual DH cannot be billed as overlapping services. Supplemental DH services, are those services provided on weekends and/or on weekdays with a service start time after 3:00 pm. Supplemental DH services are not available to individuals residing in certified residential settings with paid, professional staff, because the residence is paid for staffing on weekday evenings and anytime on weekends. Day Habilitation is limited to 6 hours a day

Any child receiving HCBS under this waiver may receive this service. Service necessity criteria for this service requires that the child must have a developmental delay justifying the need for the provision of Day Habilitation, but the child must meet NF, ICF/IID or Hospital LOC.

Children have a maximum daily amount of services that are available to individuals based upon their residence. Individuals residing in certified settings are limited to a maximum of six hours of non-residential services (or its equivalent) which must commence no later than 3 pm on weekdays.

Day Habilitation services will not include funding for direct, hands-on physical therapy, occupational therapy, speech therapy, nutrition, or psychology services. Staffing ratios cannot exceed 1:4 staff to consumers.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OPWDD Regional Office
Agency	Non-profit organization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

OPWDD Regional Office

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD Regional Offices may directly provide Day Habilitation HCBS waiver services through its regional offices.

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum. Direct service workers must have background checks. OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs, IE CYES for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Non-profit organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Non-profit organizations include: nonprofit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities. If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education under the following regulations and laws:

• Nursing (8 NYCRR Part 64, and Education Law Title 8, Article 139)
• Speech Language Pathologist (8 NYCRR Part 75, and Education Law Title 8, Article 159)
• Psychology (8 NYCRR Part 72, and Education Law Title 8, Article 153)
• Social Work (8 NYCRR Part 74, and Education Law Title 8, Article 154)
• Rehab Counselor (14 NYCRR Part 679.99)
• Dietetics/Nutrition (8 NYCRR Part 79, and Education Law Title 8, Article 157)
• Occupational Therapy (8 NYCRR Part 76, and Education Law Title 8, Article 156)
• Physical Therapy (8 NYCRR part 77, and Education Law Title 8, Article 136)
• Applied Behavioral Sciences Specialist (8 NYCRR Part 79, and Education Law Title 8, Article 167).
• Behavioral Intervention Specialist (14 NYCRR part 633-16.b(32)

Certified by the Office for People with Developmental Disabilities (OPWDD) to provide day habilitation.
Providers must have appropriate license, certification and/or approval in accordance with State requirements. Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum. Direct service workers must have background checks. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Practitioners must operate in agencies which have been designated through the NYS Children’s Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery and annually thereafter. OCFS Mandated reporter

training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs, IE CYES for all staff..
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

OPWDD Regional Offices may directly provide Day Habilitation HCBS waiver services through its regional offices.

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum. Direct service workers must have background checks. OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs, IE CYES for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Prevocational Services are individually designed to prepare a youth (age 14 or older) to engage in paid work, volunteer work or career exploration. Prevocational Services are not job-specific, but rather are geared toward facilitating success in any work environment for youth whose disabilities do not permit them access to other prevocational services. The service will be reflected in youth's plan of care and must be directed to teaching skills rather than explicit employment objectives. In addition, Prevocational Services assist with facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements.

Prevocational Services may include volunteer work, such as learning and training activities that prepare a person for entry into the paid workforce. Prevocational Services should enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines from the U.S. Department of Labor. Services are intended to develop and teach general skills. Examples include, but are not limited to:
• ability to communicate effectively with supervisors, co-workers and customers;
• generally accepted community workplace conduct and dress;
• ability to follow directions;
• ability to attend to and complete tasks;
• punctuality and attendance;
• appropriate behaviors in and outside the workplace;
• workplace problem solving skills and strategies;
• mobility training;
• career planning;
• proper use of job-related equipment and general workplace safety.

Prevocational Services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment.
• Resume writing, interview techniques, role play and job application completion.
• Exploring career options, facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements
• Assisting in identifying community service opportunities that could lead to paid employment
• Helping the youth to connect their educational plans to future career/vocational goals
• Helping youth to complete college, technical school or other applications to continue formal education/training
• Helping youth to apply for financial aid or scholarship opportunities

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Documentation is maintained that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

This service may be delivered in a one-to-one session or in a group setting of two or three participants. Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix F) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Prevocational services will not be provided to an HCBS participant if:
(i) Special education and related services that are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
(ii) Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (Access VR).
(iii) Vocational services that are provided in facility based work settings that are not integrated settings in the general community workforce.

Prevocational services are limited to 2 hours a day.

Please note: It is the responsibility of the HCBS agency to ensure that staff providing services have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology).
It is the responsibility of the Care Manager to ensure that the HCBS providers developed service plan sufficiently outlines how the service being provided will address the participant's needs reach desired goals, and that the established Frequency/Scope/Duration is appropriate meeting all HCBS requirements to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology),
OR have made arrangements for an appropriately trained and knowledgeable individual to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Prevocational Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Prevocational Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual.
• Provider agencies adhere to state cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Individual Qualifications:
• Minimum qualifications of an Associate's degree with one year human service experience. Direct service workers must have background checks.
• Preferred qualifications of a Bachelor's degree with one year experience in human services working with children/youth

Required Training
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Supervisor Qualifications:
• Minimum qualification of a Bachelor's degree with three years experience in human services. Preferred qualification of a Master's with one year experience in human services working with children/youth.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service focuses on short-term assistance provided to children/youth regardless of disability (developmental, physical and/or behavioral) because of the absence of or need for relief of the child or the child's family caregiver. Such services can be provided in a planned mode or delivered in a crisis situation. Respite workers supervise the child/youth and engage the child/youth in activities that support his/her and/ or primary caregiver/family's constructive interests and abilities.

Respite providers offer services with a level of expertise in understanding and implementing behavioral/developmental interventions required to support optimal functioning for children/youth. Respite providers will regularly communicate the details of the child/youth's intervention plan so that there is a carryover of skill from the respite source to the caregivers and treatment providers.

Planned
Planned respite services provide planned short-term relief for the child or family/primary caregivers that are needed to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavioral health and/or health care needs. The service is direct care for the child/youth by individuals trained to support the child/youth's needs. This may occur in short-term increments of time (usually during the day) or on an overnight or longer-term increment. Planned Respite activities support the plan of care goals and include providing supervision and activities that match the child/youth's developmental stage and continue to maintain the child/youth health and safety.

Crisis
Crisis Respite is a short-term care and intervention strategy for children/youth and their families that helps to alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment. It may be used when challenging behavioral or situational crises occur which the child/youth and/or family/caregiver is unable to manage without intensive assistance and support. Crisis Respite can also be used as a result of crisis intervention or from visiting the emergency room. Crisis Respite should be included on the POC to the extent that it is an element of the crisis plan or risk mitigation strategy. Crisis respite should only be used in response to an immediate crisis.

Crisis Respite services may be delivered in a home or residence by qualified practitioners, out of home/residence by staff in community-based sites, or in allowable facilities. Services offered may include: site-based crisis residence, monitoring for high risk behavior, health and wellness skill building, wellness activities, family/caregiver support, conflict resolution, and other services as needed.

Ongoing communication between child/youth or the family/primary caregiver receiving crisis respite for their child, the crisis respite staff, and the child/youth's established behavioral health and health care providers is required to assure collaboration and continuity in managing the crisis situations and identifying subsequent support and service needs.

At the conclusion of a Crisis Respite period, crisis respite staff, together with the child/youth and family/primary caregiver, and his or her established behavioral health or health care providers when needed, will make a determination as to the continuation of necessary care and make recommendations for modifications to the child's plan of care. Children are encouraged to receive Crisis Respite in the most integrated and cost-effective settings appropriate to meet their respite needs. Out of home Crisis Respite is not intended as a substitute for permanent housing arrangements.

Planned Day Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.
Planned Overnight Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.
Crisis Day Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.
Crisis Overnight Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Planned/Crisis Day respite services can be provided in the home of an eligible youth or a community setting. Planned/Crisis Overnight settings include those licensed or certified by OCFS, OMH, or OPWDD and designated to provide respite services: Foster boarding home, OCFS licensed/certified setting, OMH certified Community Residence: (community-based or state operated), including Crisis Residence. Please note there is an exemption in the CMS HCBS Final Rule (March 16, 2014) for allowable respite care settings; OR
o An OMH licensed Community Residence (community-based or state-operated), including Crisis Residence, which has an OMH Operating Certificate demonstrating compliance with 14 NYCRR 589 or 594;
OR
o OCFS Licensed agency boarding home, a group home, a group residence, or an institution and certified foster boarding homes
o OPWDD certified residential setting where the individual does not permanently reside (i.e., Family Care Home; Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID); Individualized Residential Alternative (IRA) or Community Residence (CR); or Free-Standing Respite facility under the auspices of OPWDD.

Note: Services to children and youth in foster care must comply with Part 435 of 18 NYCRR Respite is not an allowable substitute for permanent housing arrangements. For respite services that may be provided as crisis or overnight, Federal Financial Participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.
Please note: It is the responsibility of the HCBS agency to ensure that staff providing services have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology).
It is the responsibility of the Care Manager to ensure that the HCBS providers developed service plan sufficiently outlines how the service being provided will address the participant's needs reach desired goals, and that the established Frequency/Scope/Duration is appropriate meeting all HCBS requirements to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology),
OR have made arrangements for an appropriately trained and knowledgeable individual to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology. Examples include arrangement of approved Private Duty Nurse for a technology dependent child while in a respite setting.

A respite group may contain no more than 3 waiver participants. Group size will include a group of two and a group of three.
Participants living independently are not eligible to receive Respite. Respite is not a substitute for routine childcare. Respite is not an allowable substitute for medically necessary care or treatment in a residential or institutional setting.

Respite workers may attend to the participant's medical and non-medical needs and other ADLs which would ordinarily be performed by a caregiver or family member. However, unlicensed Respite workers are not permitted to utilize medical equipment, administer medications, or utilize medical devices without appropriate training by a licensed professional.

Payment may not be made for Respite provided at the same time when other services that include care and supervision are

provided.

Respite is limited to no more than 14-days, 336 hours, or 1,344 15-minute units annually, unless DOH or the MMCP has given prior approval to exceed these limits based on medical necessity. Implementation of a soft service limit for Respite will not take effect until on or after NY-DOH has fully expended all available American Rescue Plan Act (ARPA)/ Section 9817 funding or upon sunset of all remaining ARPA/ section 9817 funding, whichever occurs sooner.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OCFS licensed/certified setting including agency boarding home, a group home, a group residence, or an institution
Agency	OMH-certified Community Residence: (community-based or state operated) including Crisis Residence
Agency	OPWDD certified residential setting
Agency	Foster boarding home
Agency	Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

OCFS licensed/certified setting including agency boarding home, a group home, a group residence, or an institution

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State

prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
Respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training.

Direct service workers must have background checks. Practitioner Training Qualifications:
• Mandated Reporter
• Personal Safety / Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Supervisor Qualifications:
Minimum qualification is a Bachelor's degree with one year experience in human services working with children/youth.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

OMH-certified Community Residence: (community-based or state operated) including Crisis Residence

Provider Qualifications

License *(specify):*

Certificate *(specify):*

OMH certification

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.

• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
Facilities must have an OMH Operating Certificate demonstrating compliance with 14 NYCRR 589 or 594.
Respite workers must be staff of the certified program. Direct service workers must have background checks.

Practitioner Training Qualifications:
• Mandated Reporter
• Personal Safety / Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Supervisor Qualifications: Minimum qualification is a Bachelor's degree with one year experience in human services working with children/youth.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

OPWDD certified residential setting

Provider Qualifications

License *(specify):*

Certificate *(specify):*

OPWDD certification

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State training prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.

• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
Facility where the individual does not permanently reside (i.e., Community-based or state-operated OPWDD-certified setting, Family Care Home; Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID); Individualized Residential Alternative (IRA) or Community Residence (CR); or Free-Standing Respite facility under the auspices of OPWDD. Direct service workers must have background checks.

Respite workers must be staff of the certified program.

Practitioner Training Qualifications:
• Mandated Reporter
• Personal Safety / Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Supervisor Qualifications:
In an OPWDD-certified setting, supervisors in the provision of Respite in the Children's Waiver must have over 3 years' experience in the certified setting and such provision is under the oversight of a licensed professional, Qualified Intellectual Disabilities Professional (QIDP), or master's level professional in a Behavioral Health field.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Foster boarding home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements:
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.

• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State training prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
Respite providers must be a Licensed Foster Parent pursuant to Part 435 of 18 NYCRR Direct service workers must have background checks.

Practitioner Training Qualifications:
• Mandated Reporter
• Personal Safety / Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Supervisor Qualifications:
Minimum qualification is a Bachelor's degree with one year experience in human services working with children/youth.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provision of service in child's residence or other community-based setting (e.g. park, shopping center, etc.):
Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements:
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State

prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Individual Staff Qualifications:
o Respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training, and has experience working with children/youth (preference given to those with experience working with children/youth with special needs);
A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS)
o Direct service workers must have background checks.

Practitioner Training Qualifications:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Supervisor Qualifications:
• Minimum qualification is a Bachelor’s degree with one year experience in human services working with children/youth.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

03 Supported Employment	03021 ongoing supported employment, individual

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Supported Employment services are individually designed to prepare youth with disabilities (age 14 or older) to engage in paid work. Supported Employment services provide assistance to participants with disabilities as they perform in a work setting.

Supported Employment provides ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self- employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, career advancement services, and other workplace support services including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting.

Supported employment services may also include services and supports that assist the participant in achieving self-employment through the operation of a business including home-based self-employment. However, Medicaid funds are not used to defray the expenses associated with starting up or operating a business.
In addition to the need for an appropriate job match that meets the individual’s skills and interests, individuals may also need long term employment support to successfully maintain a job due to the ongoing nature of the HCBS participant’s support needs, changes in life situations, or evolving and changing job responsibilities.

Supported employment services may be provided in a variety of settings, particularly work sites. Supported employment services include the following:
• Supervision and training that are not job-related
• Intensive ongoing support
• Transportation to and from the job site
• Interface with employers regarding the individual’s disability(ies) and needs related to his or her healthcare issue(s)
• Other activities needed to sustain paid work (e.g., employment assessment, job placement, and/or adaptive/assistive technology necessary for employment)
• Job finding and development training in work behaviors
• assessing the interest and fit of an individual for particular job opportunities, staff work with employers and job sites preparing them to be able to make necessary and reasonable accommodations
• On-site support for the individual as they learn specific job tasks
• Monitoring through on-site observation through communication with job supervisors and employers. Supported employment is provided through individual face-to-face intervention.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix F) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other

community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.
Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

Supported Employment service will not be provided to an HCBS participant if:
(i) Special education and related services that is otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
(ii) Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973, and the provision of supported employment would be duplicative of such services.
(iii) Supported employment does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.
(iv) Supported employment does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.
(v) Supported employment does not include volunteer work. Such volunteer learning and un-paid training activities that prepare a person for entry into the paid workforce are addressed through pre-vocational services.

Medicaid funding cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
• Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
• Payments that are passed through to users of supported employment services.

Supported employment is limited to 3 hours per day.

Please note: It is the responsibility of the HCBS agency to ensure that staff providing services have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology).
It is the responsibility of the Care Manager to ensure that the HCBS providers developed service plan sufficiently outlines how the service being provided will address the participant's needs reach desired goals, and that the established Frequency/Scope/Duration is appropriate meeting all HCBS requirements to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology),
OR have made arrangements for an appropriately trained and knowledgeable individual to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
Individual Qualifications:
• Minimum qualifications of an Associate's degree with one year human service experience. Direct service workers must have background checks.
• Preferred qualifications of a Bachelor's degree with one year experience in human services working with children/youth
Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Supervisor Qualifications:
• Minimum qualification of a Bachelor's degree with three years of experience in human services.
• Preferred qualification of a Master's with one year experience in human services working with children/youth.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adaptive and Assistive Technology

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service provides technological aids and devices identified within the child's Plan of Care (POC) which enable him/her to accomplish daily living tasks that are necessary to support the health, welfare, and safety of the child. The service is administered by a Financial Management Services (FMS) agency for billing purposes, even if this is the only self-directed service that the person accesses.

Adaptive and Assistive Technology includes :
Direct selection communicators, Alphanumeric communicators, Scanning communicators, Encoding communicators, Speech amplifiers, Electronic speech aids/devices, Voice activated, light activated, motion activated and electronic devices, Standing boards/frames and therapeutic technology for the purpose of maintaining or improving the participant's strength, mobility or flexibility to perform activities of daily living, Adaptive switches/devices, Meal preparation and eating aids/devices/appliances, Specially adapted locks, Motorized wheelchairs. Electronic, wireless, solar-powered or other energy powered devices that demonstrate to the satisfaction of the commissioner, or designee, that the device(s) will significantly enable the participant to live, work or meaningfully participate in the community with less reliance on paid staff supervision or assistance. Such devices include computers, observation cameras, sensors, telecommunication screens and/or telephones and/or other, telecare support services/systems that enable the participant to interact with remote staff to ensure health and safety. Such devices cannot be used for the purpose of surveillance, but to support the person to live with greater independence, Devices to assist with medication administration, including tele-care devices that prompt, teach or otherwise assist the participant, Portable generators necessary to support technology or devices needed for the health or safety of the person, and stretcher stations.

Adaptive and Assistive Technology Services include:
A. the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
B. services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the participants;
C. services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
D. training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates or authorized representatives of the participant; and

E. training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Remote training for use of the Adaptive and Assistive technology is provided at the time of the service being provided and is not ongoing support or monitoring. The training for Adaptive and Assistive technology will include how to use the technology during the initial set-up including turning the technology on/off. For example, the training regardless of whether it is in person, via phone/Skype, or telehealth will include how to set up and turn the technology on/off. Remote training delivery allows the participant to receive the Adaptive and Assistive technology more quickly, resulting in youth avoiding institutional placement or placement in a more restrictive living environment or transitioning from those care settings more quickly. This will allow youth to enhance/increase the individual's independence and to fully integrate in the community and participate in community activities.
The participant may request the training be in person or fully remotely 100 percent of time with no in-person. Participants have an opportunity to select in-person training. Remote training delivery will only be utilized when the training may be appropriately delivered remotely. The Adaptive and Assistive Technology goals and training modality will be discussed with the family and documented in the individual's person-centered service plan prior to use. The plan will document the type of delivery of training needed, requested, and selected by the child and family.
The training is not anticipated to be on-going and will not violate the family or participant's privacy. The training will be delivered through HIPAA compliant methods in a manner accepted by the State's HIPAA compliance officer. The child/youth and family may remotely receive the training associated with the Adaptive and Assistive Technology in the room of their choice (not the bedroom or bathroom) and they may turn the training off if they so choose. They will be informed of this choice during their person-centered planning meeting. The HHCM will ensure that the child/youth's needs are being addressed including understanding how to use Adaptive and Assistive Technology and that health and welfare needs are being addressed. The SMA ensures the health and safety of waiver participants when their services are delivered via telehealth/remotely through an incident management system, established health care standards, and monitor those standards based on the responsibility of the service provider. HHCM use the incident management system, health care standards and monitoring to ensure that remote delivery of training is consistent with the waiver standards. HHCM monitor the remote training delivery for Adaptive and Assistive Technology according to the acuity contact schedule.
In the event of technology failure and as a back-up, the remote training will be rescheduled.

The Health Home Care Manager (HHCM) uses the incident management system, health care standards and monitoring to ensure that remote delivery of training is consistent with the waiver standards. Remote training delivery will only be utilized when the training may be appropriately delivered remotely.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The adaptive and assistive technology available through the HCBS authorities cannot duplicate technology otherwise available through the Medicaid State Plan at 1905(a) of the Social Security Act or other federal/state funding streams. Technology must be beyond the scope of Durable Medical Equipment (DME) and the least restrictive to the enrollee.

Adaptive and Assistive Technology are expected to be a one-time only purchase. Replacements, repairs, upgrades, or enhancements made to existing technology will not be paid by the Children's Waiver unless determined defective or issue with the technology. This is a remote delivery component of this service. The HHCM will ensure, that where appropriate, justification from physicians, or other specialists or clinicians has been obtained.

Warranties, repairs or maintenance on assistive technology only when most cost effective and efficient means to meet the need, and are not available through the Medicaid state plan at 1905(a) or third-party resources.

Cost Limits
AAT services have an established limit per service of $15,000 per year. That limit cannot be exceeded without special circumstances, supporting documentation meeting specific NYSDOH requirements, and prior approval from FMS/NYSDOH.
Adaptive and Assistive Technology may be initiated up to 180 days prior to discharge from an institutional setting, but may not be billed until the child/youth is discharged.

For Adaptive and Assistive Technology, the FMS is the provider of record for FFS. Services are only billed to Medicaid once the technology is procured.

The FMS secures a vendor qualified to complete the required work. Activities include and are not limited to determining the need for the service, the safety of the proposed technology, its expected benefit to the child, and the most cost effective approach to fulfill the child's need. Standard provisions of the NYS Finance Law and procurement policies must be

followed to ensure that vendors are qualified and that State required bidding procedures have been followed. Services are only billed to Medicaid by the FMS once the technology is verified as received and the amount billed is equal to the contract value.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FMS

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adaptive and Assistive Technology

Provider Category:

Agency

Provider Type:

FMS

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

FMS staff verify the qualifications of Adaptive and Assistive Technology vendor: a. Must be familiar with the Adaptive and Assistive Technology policies permitted in the waiver program as described in the program manual; the FMS should supply the evaluator with a copy of both prior to initiation of the evaluation. b. Must be able to communicate well with all parties involved with the purchase of the technology and any training needed, e.g. consumers, contractors, and local government officials. c. Must be able to clearly describe in writing, and by design, the proposed purchase. d. Must have knowledge of assistive technology and specific adaptive technology appropriate for the child’s needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS will verify vendor qualifications, DOH will verify FMS qualifications.

Frequency of Verification:

Provider qualifications are verified at the beginning of the purchase by the FMS.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Caregiver/Family Advocacy and Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Caregiver/Family Advocacy and Support Services enhance the child/youth's ability regardless of disability (developmental, physical and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child/youth in the home and/or community. Family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Note: this service is not the State Plan service of Family Peer Support Services which is required to be delivered by a certified/credentialed Family Peer with lived experience. This service provides children/youth, family, caregiver(s), and collateral contacts with techniques and information not generally available so that they can better respond to the needs of the participant. Family, caregiver(s) and collateral contacts include family members, individuals identified by the participant, as well as other paid and non-paid individuals who may supervise or provide care to the member. The use of this service may appropriately be provided to prevent problems in community settings as well as when the child/youth is experiencing difficulty. The Plan of Care objectives must clearly state how the service can prevent as well as ameliorate existing problems and to what degree. This service cannot be used to develop an Individualized Education Program (IEP), the plan for students with disabilities who meet the federal and state requirements for special education, or to provide special education services to the child/youth. Participating in community events and integrated interests/occupations are important activities for all children/youth, including those with disabilities (developmental, physical and/or behavioral health in origin). Success in these activities is dependent not only on the child/youth, but on the people who interact with and support the child/youth in these endeavors. This service improves the child/youth's ability to gain from the community experience, and enables the child/youth's environment to respond appropriately to the child/youth's disability and/or health care issues.

Based upon the Caregiver/Family Advocacy and Support Services plan developed by the child/youth and caregiver/family team, this service provides opportunities to:

• Interact and engage with family/caregivers and children/youth to offer educational, advocacy, and support resources to develop family/caregivers' ability to independently access community services and activities;

• Maintain and encourage the caregivers'/families' self-sufficiency in caring for the child/youth in the home and community;
• Address needs and issues of relevance to the caregiver/family unit as the child/youth is supported in the home and community; and

• Direct instruction and guidance in the principles of children's chronic condition or illness. This service may be provided individually or in a group in-person intervention (no more than three HCBS eligible children/families). This also includes direct self-advocacy training in the community with collateral contacts regarding the child/youth's disability(ies) and needs related to his
or her health care issues). Self-advocacy training for the child/youth and/or family/caregiver, including during community transitions. This service is provided individually or in a group in-person intervention.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix F) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.
• This service cannot be delivered nor billed while an enrolled child is in an in-eligible setting, including hospitalization.
• This service cannot include Special education and related services that is otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
• This service may be provided in group settings but no more than three eligible children/youth or 12 participants (children and collaterals) may attend a group activity at the same time.
• Caregiver Family Advocacy and Support Services are limited to 6 hours per day.

Please note: It is the responsibility of the HCBS agency to ensure that staff providing services have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology).
It is the responsibility of the Care Manager to ensure that the HCBS providers developed service plan sufficiently outlines how the service being provided will address the participant's needs reach desired goals, and that the established Frequency/Scope/Duration is appropriate meeting all HCBS requirements to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology),
OR have made arrangements for an appropriately trained and knowledgeable individual to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Caregiver/Family Advocacy and Support Services

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Supervisor Qualifications:
• Minimum qualification of a Level I practitioner supervisor requires a Bachelor's degree with one year experience in human services working with children/youth. Preferred two years' experience in Human Services working with children/youth.
• Minimum qualification for Level II practitioners requires a Master's degree with one year experience or bachelor's degree with four years of experience in human services working with children/youth. Preferred experience for master's degree of two years of experience in human services working with children/youth.

Individual Staff Qualifications:
Level 1 Minimum qualification for a practitioner requires a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS) with related human service experience. Direct service workers must have background checks. Preferred experience working with children/youth.
• Level 2 Preferred Qualifications: An individual employed by the agency with a Master's degree in education, or a Master's degree in a human services field plus one year of applicable experience. Direct service workers must have background checks.
• Level 2 Minimum Qualifications: An individual employed by the agency with a bachelor's degree plus two years of related experience

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service provides internal and external physical adaptations to the home or other eligible residences of the enrolled child which per the child's plan of care (POC) are identified as necessary to support the health, welfare and safety of the child or that enable the child to function with greater independence in the home and without which the child would require institutional and/or more restrictive living setting. The service is administered by a Financial Management Services (FMS) agency for billing purposes, even if this is the only self-directed service that the person accesses.

Service Components Environmental Modifications
Modifications include but not limited to: installation of ramps, hand rails and grab-bars, widening of doorways(but not hallways), modifications of bathroom facilities, installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and technology and supplies needed for the welfare of the recipient, lifts and related equipment, elevators when no feasible alternative is available, automatic or manual door openers/bells, modifications of the kitchen necessary for the participant to function more independently in his home, medically necessary air conditioning, Braille identification systems, tactile orientation systems, bed shaker alarm devices, strobe light smoke detection and alarm devices, small area drive-way paving for wheel-chair entrance/egress from van to home, safe environment modifications for behaviorally challenged participants require the prior review of a behavioral specialist and include window protections, reinforcement of walls, durable wall finishes, open-door signal devices, fencing, video monitoring systems and shatter-proof

shower doors; and future technology devices that allow the participant to live more safely and independently to avoid possible institutional placement or placement in a more restrictive living environment, which are available at a reasonable cost in comparison to living in a more restrictive residential setting. The scope of environmental modifications will also include necessary assessments to determine the types of modifications needed.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services are delivered through FFS and require prior authorization by the FMS. The FMS in conjunction with NYSDOH must approve any purchase exceeding established limits.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the child. Adaptations that add to the total square footage of the home's footprint are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Also excluded are pools and hot tubs and associated modifications for entering or exiting the pool or hot tub. Environmental modifications cannot reimburse for new square footage or an already renovated space.

Repair & Replacement of Modification: In most instances, a specific type of Environmental Modification is a one- time benefit. However, in reasonable circumstances determined and approved by the State, a second modification may be considered for funding as follows: if a person moves to another home; if the current modifications are in need of repair, worn-out or unsafe; or if a participant wishes to spend considerable time with a non-cohabitating parent in their home and such modifications are required to ensure health and safety during these periods.

State policy places certain limitations on environmental modifications requested when the home/apartment is a leased space, including property owner sign-off on the modification and limitations on federal/state liability for the cost of removal/replacement/repair of items in public spaces of rental properties.

Accessibility Modification Limits
Only those services not reimbursable under the Medicaid State Plan under 1905(a) of the Social Security Act or other federal/state funding streams will be reimbursable under the HCBS Waiver.

Environmental modifications have a service limitation and may not exceed $25,000 per year special circumstances, medical necessity documentation meeting specific DYSDOH requirements and without prior approval from the FMS/ NYS DOH. Environmental modifications may be initiated up to 180 days prior to discharge from an institutional setting, but may not be billed until the child/youth is discharged. Under Environmental Modifications, the practice of “balance billing” or requiring/allowing families to fund some of the cost of a service from their own funds is prohibited under Federal and New York law.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FMS

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

FMS

Provider Qualifications

License *(specify):*

Licensure appropriate to the trade

Certificate *(specify):*

Other Standard *(specify):*

FMS staff verify the qualifications of home modification providers present the following knowledge and skills: a. Must be familiar with the home adaptation policies permitted in the waiver program as described in state guidance; the FMS should supply the evaluator with a copy of both prior to initiation of the evaluation. b. Must be able to communicate well with all parties involved with the development of home adaptations, e.g. consumers, contractors, and local government officials. c. Must be able to clearly describe in writing, and by design, the proposed home adaptation. d. Must know and be able to apply the New York State Building Code, Current Accessibility Standards, and the Federal Accessibility Guidelines found in the Fair Housing Amendment Act (as applicable to the home modification) e. Must have knowledge of assistive technology and specific adaptive technology appropriate for the child's needs. f. Must have skill in design/drafting in order to clearly describe the proposed modification. g. Must be able to complete all components of an On-Site Evaluation as in Section (x) of this manual

Contractors performing any adaptation for a child in the waiver program is required to:
a. Be bonded;
b. Maintain adequate and appropriate licensure;
c. Obtain any and all permits required by state and local municipality codes for the modification; and
d. Agree that before final payment is made the contractor must show that the local municipal branch of government that issued the initial permit has inspected the work.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS will verify vendor qualifications, DOH will verify FMS qualifications.

Frequency of Verification:

Provider qualifications are verified at the beginning of the home modification contract by the FMS and at least every 3 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Financial Management Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Financial Management Service (FMS) assists the family or participant to purchase Assistive and Adaptive Technology (AAT), Vehicle Modifications (VMods), Transitional Services, or Environmental Modifications (EMods) authorized in the plan of care on the participant's behalf and bill the costs of such AAT, Transitional Services, E/V Mods to the state. The FMS is not required to have an agreement with a vendor but there must be documentation to verify the purchase of the AAT, EMods, Transitional Services, or VMods and the AAT, EMods, Transitional Services, and VMods must meet the standards specified in the waiver. The FMS will be provided under the proposed initial/concurrent 1915(b)(4) for Selective Contracting via FFS. An individual must choose an FMS if the following services are included in their service plan in order to provide for appropriate billing and claiming: Adaptive and Assistive Technology, Vehicle Modifications, Transitional Services, or Environmental Modifications. The FMS supports the individual with billing and payment of approved Adaptive and Assistive Technology, Vehicle Modifications, Transitional Services, or Environmental Modifications fiscal accounting and reporting, ensuring Medicaid and corporate compliance, and general administrative supports. The FMS supports the individual with only billing and payment of approved Adaptive and Assistive Technology, Vehicle Modifications, Transitional Services, or Environmental Modifications.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The FMS will process and pay invoices for Adaptive and Assistive Technology, Vehicle Modifications, Transitional Services, or Environmental Modifications approved in the plan of care. For each project, Transitional Services, or piece of technology, the FMS will bill for a unit of FMS consistent with the State's fee schedule. Environmental Modifications, Vehicle Modifications, Adaptive and Assistive Technology, and Transitional Services may be initiated up to 180 days prior to discharge from an institutional setting, but may not be billed until the child/youth is discharged.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Health Home

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Health Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled as a Health Home in the New York Medicaid Agency and agreeing to all CMS required FMS protections in their administrative contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS will verify vendor qualifications, DOH will verify FMS qualifications.

Frequency of Verification:

Provider qualifications are verified at the beginning of the purchase by the FMS.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Non-Medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are available for individuals to access authorized HCBS and destinations that are related to a goal included on the child/youth's Plan of Care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transportation utilization is for a specific period and specified duration as outlined in policy as indefinite recurring trips (e.g., regular commuting for work) are not allowed. However, short-term goals related to activities in the plan of care are eligible for transportation coverage. Non-Medical transportation can be utilized when previous transportation or support cannot provide transportation for a period of time, (e.g. car repair needed or caregiver can longer transport due to change in schedule). Individuals receiving residential services are ineligible for Non-Medical Transportation. This service will be provided to meet the participant's needs as determined by an assessment performed in accordance with Department requirements and as outlined in the participant's plan of care.
The care manager must document a need for transportation to support an individual's identified goals. The Health Home Care Manager will include justification for this service within the Person-Centered Plan of Care. The HHCM will be responsible for completing documentation of which goals in an individual's Plan of Care to which the trips will be tied.

For each participant utilizing Non-Medical Transportation, the Transportation Manager will provide a monthly report of authorized trips to the State.

Generally, the same rules used to determine reimbursement of trips to medical appointments should be followed when considering reimbursement of non-medical trips for eligible participants.
The following guidelines apply to Non-Medical Transportation:
• Transportation must be tied to a goal in the Plan of Care.
• Transportation is available for a specified duration as indefinite recurring trips are not allowed.
• Individuals receiving residential services are ineligible for Non-Medical Transportation.
• Use transportation available free of charge.
• Use the medically appropriate mode of transportation.
• Travel within the common marketing area.
• When possible, trips should be combined.
• Justify need for travel outside the common marketing area.
• Requests for personal vehicles to be utilized for non-medical transportation must follow the process for prior approval before the transportation is conducted.
• Vouchers submitted for personal vehicle mileage reimbursement must be submitted within 90 days of the date of service. Only when there are extenuating circumstances, will the Department allow payment for trips that are submitted after the 90 day time period. These requests will be considered on a case-by-case basis provided valid justification is given.
• Reimbursement for travel can be denied when the destination does not support the participant's integration into the community.
• A participant's Plan of Care outlines the general parameters of his or her Non-Medical Transportation needs. However, these needs can change or be amended based upon the participant's stated goals and/or successful ongoing integration into the community.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**
☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transportation Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Transportation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

All children are eligible for this service regardless of whether they are in the managed care or FFS delivery system. This service is delivered outside of the MCO contracts. All non-medical transportation is billed via the FFS delivery system. Agencies interested in providing Non-Medical Transportation must be enrolled in the FFS program as a current Medicaid Transportation Provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Palliative care - Expressive Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Palliative care is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or illness. The goal is to improve quality of life for both the child and the family.
Palliative care is provided by a specially-trained team of doctors, nurses, social workers and other specialists who work together with a child's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or illness and can be provided along with curative treatment.
Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions.

• Expressive Therapy (art, music and play) – Help children better understand and express their reactions through creative and kinesthetic treatment

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community
integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Expressive Therapy (art, music and play) – Help children better understand and express their reactions through creative and kinesthetic treatment. Limited to the lesser of four appointments per month or 48 hours per calendar year. This limit can be exceeded when medically necessary.
Please note: It is the responsibility of the HCBS agency to ensure that staff providing services have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology).
It is the responsibility of the Care Manager to ensure that the HCBS providers developed service plan sufficiently outlines how the service being provided will address the participant's needs reach desired goals, and that the established Frequency/Scope/Duration is appropriate meeting all HCBS requirements to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology),
OR have made arrangements for an appropriately trained and knowledgeable individual to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**
☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospice Organization
Agency	Certified Home Health Agency (CHHA)
Agency	Provider Agency
Agency	Article 28 Clinic

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care - Expressive Therapy

Provider Category:

Agency

Provider Type:

Hospice Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, c certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care.

Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches

• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Expressive Therapy (art, music and play) Child Life Specialist with certification through the Child Life Council a Creative Arts Therapist licensed by the State of New York ,a Music Therapist with a Bachelor's Degree from a program recognized by the NYS Education Department, or a Play Therapist with Master's Degree, from a program recognized by the New York State Education Department and a current Play Therapist Registration conferred by the Association for Play Therapy (Expressive Therapy (Art, Music and Play). Student interns practicing within the scope of the New York State Education law and supervised by a licensed practitioner in that profession can deliver HCBS; student
interns and limited permittees can treat Medicaid enrollees under the supervision of a licensed practitioners in that profession who must be enrolled as a Medicaid provider. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care - Expressive Therapy

Provider Category:

Agency

Provider Type:

Certified Home Health Agency (CHHA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Non-profit/voluntary/private as established in NYS Public Health Law §4004. Certified Home Health Agency (CHHA); PHL Sections 3602, 3606

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the

medically fragile population, preferably involving palliative care.

Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Expressive Therapy (art, music and play) Child Life Specialist with certification through the Child Life Council a Creative Arts Therapist licensed by the State of New York ,a Music Therapist with a Bachelor's Degree from a program recognized by the NYS Education Department, or a Play Therapist with Master's Degree, from a program recognized by the New York State Education Department and a current Play Therapist Registration conferred by the Association for Play Therapy (Expressive Therapy (Art, Music and Play). Student interns practicing within the scope of the New York State Education law and supervised by a licensed practitioner in that profession can deliver HCBS; student interns and limited permittees can treat Medicaid enrollees under the supervision of a licensed practitioners in that profession who must be enrolled as a Medicaid provider. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care - Expressive Therapy

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must work within a child serving agency or agency with children's behavioral health and health experience designated through the NYS Children's Provider Designation Review Team to provide the services referenced in the definition. This requires agencies to have the appropriate license, certification and/or approval in accordance with State designation requirements by OMH, OASAS, OCFS or DOH.
• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all

staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care.

Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Expressive Therapy (art, music and play) Child Life Specialist with certification through the Child Life Council a Creative Arts Therapist licensed by the State of New York, a Music Therapist with a Bachelor's Degree from a program recognized by the NYS Education Department, or a Play Therapist with Master's Degree, from a program recognized by the New York State Education Department and a current Play Therapist Registration conferred by the Association for Play Therapy (Expressive Therapy (Art, Music and Play). Student interns practicing within the scope of the New York State Education law and supervised by a licensed practitioner in that profession can deliver HCBS; student interns and limited permittees can treat Medicaid enrollees under the supervision of a licensed practitioners in that profession who must be enrolled as a Medicaid provider. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care - Expressive Therapy

Provider Category:

Agency

Provider Type:

Article 28 Clinic

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.

• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care.

Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Expressive Therapy (art, music and play) Child Life Specialist with certification through the Child Life Council a Creative Arts Therapist licensed by the State of New York, a Music Therapist with a Bachelor's Degree from a program recognized by the NYS Education Department, or a Play Therapist with Master's Degree, from a program recognized by the New York State Education Department and a current Play Therapist Registration conferred by the Association for Play Therapy (Expressive Therapy (Art, Music and Play). Student interns practicing within the scope of the New York State Education law and supervised by a licensed practitioner in that profession can deliver HCBS; student
interns and limited permittees can treat Medicaid enrollees under the supervision of a licensed practitioners in that profession who must be enrolled as a Medicaid provider. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Palliative care – Counseling and Support Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Palliative care – Counseling and Support Service is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or illness. The goal is to improve quality of life for both the child and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers and other specialists who work together with a child's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or illness and can be provided along with curative treatment. Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions AND illnesses. Counseling and Support Service – Help for participants and their families to cope with grief related to the participant's chronic condition or illness. Counseling and Support Services are inclusive for those participants in receipt of hospice care through a hospice provider.

This service includes palliative care counseling plan of care development consistent with CMS guidelines and ensures that certain administrative duties are performed when a child on the waiver passes away.

Counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to 6 months.
Palliative care: Counseling and Support Service, is a historic waiver service requiring the development of a care plan based on a licensed mental health practitioner ascertaining that family members are grieving. The Counseling care plan has historically been utilized in the Waiver, State Plan and Medicare to ensure beneficiaries receive needed family counseling after a waiver child's death consistent with the HCBS technical guide and State Plan hospice guidance. Because the language was not clear, the reimbursement does not clearly outline, and the procedure was not stated explicitly, waiver members were not utilizing this service. The addition of the per-episode units linked to the counseling care plan is intended to increase utilization of this service and explain to providers, care managers and beneficiaries how to utilize and be reimbursed for this service more fully in the future.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community
integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants. Counseling and Support Services can be provided to participants who are receiving services with a hospice care provider, if the services are not duplicative.

Counseling and Support Service – Help for participants and their families to cope with grief related to the participant's chronic condition and illness and certain duties performed when a child on the waiver passes away. Counseling services are inclusive for those participants in receipt of hospice care through a hospice provider. All others are limited to the lesser of 5 hours per month or 60 hours per calendar year.

Please note: It is the responsibility of the HCBS agency to ensure that staff providing services have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology).

It is the responsibility of the Care Manager to ensure that the HCBS providers developed service plan sufficiently outlines how the service being provided will address the participant's needs reach desired goals, and that the established Frequency/Scope/Duration is appropriate meeting all HCBS requirements to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology),
OR have made arrangements for an appropriately trained and knowledgeable individual to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospice Organization
Agency	Article 28 Clinic
Agency	Provider Agency
Agency	Health Homes
Agency	Certified Home Health Agency (CHHA)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Counseling and Support Service

Provider Category:

Agency

Provider Type:

Hospice Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.

• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care. Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Counseling Service A Licensed Clinical Social Worker (LCSW), a Licensed Master Social Worker (LMSW), a Licensed Psychologist or a Licensed Mental Health Counselor, that meet current NYS licensing. Student interns practicing within the scope of the New York State Education law and supervised by a licensed practitioner in that profession can deliver HCBS; student interns and limited permittees can treat Medicaid enrollees under the supervision of a licensed practitioners in that profession who must be enrolled as a Medicaid provider. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Counseling and Support Service

Provider Category:

Agency

Provider Type:

Article 28 Clinic

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)

• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care. Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Counseling Service A Licensed Clinical Social Worker (LCSW), a Licensed Master Social Worker (LMSW), a Licensed Psychologist or a Licensed Mental Health Counselor, that meet current NYS licensing. Student interns practicing within the scope of the New York State Education law and supervised by a licensed practitioner in that profession can deliver HCBS; student interns and limited permittees can treat Medicaid enrollees under the supervision of a licensed practitioners in that profession who must be enrolled as a Medicaid provider. Direct service workers must have background checks.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Counseling and Support Service

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must work within a child serving agency or agency with children’s behavioral health and health experience

designated through the NYS Children's Provider Designation Review Team to provide the services referenced in the definition. This requires agencies to have the appropriate license, certification and/or approval in accordance with State designation requirements by OMH, OASAS, OCFS or DOH.
• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care. Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Counseling Service A Licensed Clinical Social Worker (LCSW), a Licensed Master Social Worker (LMSW), a Licensed Psychologist, Licensed Creative Arts Therapist or a Licensed Mental Health Counselor, that meet current NYS licensing. Student interns practicing within the scope of the New York State Education law and supervised by a licensed practitioner in that profession can deliver HCBS; student interns and limited permittees can treat Medicaid enrollees under the supervision of a licensed practitioners in that profession who must be enrolled as a Medicaid provider. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Counseling and Support Service

Provider Category:

Agency

Provider Type:

Health Homes

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled as a Health Home under the New York Medicaid Agency. For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every 3 years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Counseling and Support Service

Provider Category:

Agency

Provider Type:

Certified Home Health Agency (CHHA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Non-profit/voluntary/private as established in NYS Public Health Law §4004. Certified Home Health Agency (CHHA); PHL Sections 3602, 3606

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care. Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Counseling Service A Licensed Clinical Social Worker (LCSW), a Licensed Master Social Worker (LMSW), a Licensed Psychologist or a Licensed Mental Health Counselor, that meet current NYS licensing. Student interns practicing within the scope of the New York State Education law and supervised by a licensed practitioner in that profession can deliver HCBS; student interns and limited permittees can treat Medicaid enrollees under the supervision of a licensed practitioners in that profession who must be enrolled as a Medicaid provider. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Palliative care – Massage Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Palliative care – Massage Therapy is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or illness. The goal is to improve quality of life for both the child and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers and other specialists who work together with a child's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or illness and can be

provided along with curative treatment.
Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions.

Massage Therapy – To improve muscle tone, circulation, range of motion and address physical symptoms related to their illness as well as provide physical and emotional comfort, pain management, and restore the idea of healthy touch for children/youth who are dealing with treatments that may involve painful interventions and ongoing and/or past trauma.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community
integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Massage Therapy –Limited to no more than 12 appointments per calendar year. This limit can be exceeded when medically necessary.
Please note: It is the responsibility of the HCBS agency to ensure that staff providing services have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology).

It is the responsibility of the Care Manager to ensure that the HCBS providers developed service plan sufficiently outlines how the service being provided will address the participant's needs reach desired goals, and that the established Frequency/Scope/Duration is appropriate meeting all HCBS requirements to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology),
OR have made arrangements for an appropriately trained and knowledgeable individual to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agency
Agency	Hospice Organization
Agency	Article 28 Clinic
Agency	Certified Home Health Agency (CHHA)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Massage Therapy

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must work within a child serving agency or agency with children's behavioral health and health experience designated through the NYS Children's Provider Designation Review Team to provide the services referenced in the definition. This requires agencies to have the appropriate license, certification and/or approval in accordance with State designation requirements by OMH, OASAS, OCFS or DOH.

• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.

• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)

• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.

• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.

• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.

• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.

• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care. Required Training:

• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Massage Therapist - A Licensed Therapist that meets current NYS licensing. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

Entity Responsible for Verification:
DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Massage Therapy

Provider Category:

Agency

Provider Type:

Hospice Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.

• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care. Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Massage Therapy Massage Therapist currently licensed by the State of New York. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Massage Therapy

Provider Category:

Agency

Provider Type:

Article 28 Clinic

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.
- Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.

- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care. Required Training:

- Mandated Reporter
- Personal Safety/ Safety In The Community
- Strength Based Approaches
- Suicide prevention training
- Domestic Violence Signs and Basic Interventions
- Trauma Informed Care

Massage Therapy Massage Therapist currently licensed by the State of New York. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Massage Therapy

Provider Category:

Agency

Provider Type:

Certified Home Health Agency (CHHA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Non-profit/voluntary/private as established in NYS Public Health Law §4004. Certified Home Health Agency (CHHA); PHL Sections 3602, 3606

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.

• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care. Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Massage Therapy Massage Therapist currently licensed by the State of New York. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Palliative care – Pain and Symptom Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Palliative care – Pain and Symptom Management is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or illness. The goal is to improve quality of life for both the child and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers and other specialists who work together with a child's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or illness and can be provided along with curative treatment.
Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions.
Types of activities included: Counseling and Support Services; Pain and Symptom Management; Expressive Therapy (Art, Music and Play); and Massage Therapy.
• Pain and Symptom Management – Relief and/or control of the child's suffering related to their illness or condition (examples: Acupuncture, meditation. see www.getpalliativecare.org)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community
integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Pain and Symptom Management – Relief and/or control of the child's suffering related to their illness or condition. No limit; as required by participant's physician.
Please note: It is the responsibility of the HCBS agency to ensure that staff providing services have adequate training and

knowledge to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology).

It is the responsibility of the Care Manager to ensure that the HCBS providers developed service plan sufficiently outlines how the service being provided will address the participant's needs reach desired goals, and that the established Frequency/Scope/Duration is appropriate meeting all HCBS requirements to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology),
OR have made arrangements for an appropriately trained and knowledgeable individual to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Home Health Agency (CHHA)
Agency	Hospice Organization
Agency	Article 28 Clinic

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Pain and Symptom Management

Provider Category:

Agency

Provider Type:

Certified Home Health Agency (CHHA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Non-profit/voluntary/private as established in NYS Public Health Law §4004. Certified Home Health Agency (CHHA); PHL Sections 3602, 3606

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State

prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care. Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Pediatrician or Family Medicine Physician, board certified in Pediatrics or Family Medicine licensed by the State of New York, a Nurse Practitioner licensed by the State of New York (Pain and Symptom Management) or a Registered Nurse licensed by the State of New York under the direct supervision of a Pediatrician or medicine physician, board certified in Pediatrics. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Pain and Symptom Management

Provider Category:

Agency

Provider Type:

Hospice Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.

• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care. Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Pediatrician or Family Medicine Physician, board certified in Pediatrics or Family Medicine licensed by the State of New York, a Nurse Practitioner licensed by the State of New York (Pain and Symptom Management) or a Registered Nurse licensed by the State of New York under the direct supervision of a Pediatrician or medicine physician, board certified in Pediatrics. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Pain and Symptom Management

Provider Category:

Agency

Provider Type:

Article 28 Clinic

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in the NYS Children's HCBS manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals

from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery and annually thereafter. OCFS Mandated reporter training is required without substitution from other mandated training. An Annual Certificate of completion should be kept on file by the HCBS providers and HHs for all staff.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of one year working with the medically fragile population, preferably involving palliative care. Required Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Pediatrician or Family Medicine Physician, board certified in Pediatrics or Family Medicine licensed by the State of New York, a Nurse Practitioner licensed by the State of New York (Pain and Symptom Management) or a Registered Nurse licensed by the State of New York under the direct supervision of a Pediatrician or medicine physician, board certified in Pediatrics. Direct service workers must have background checks

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transitional Care Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Transitional Care Coordination is available to eligible children defined as those children 1 year or older who have been institutionalized or hospitalized continuously one year or longer, or, in the case of infants aged 12 months or younger, infants who have been institutionalized or hospitalized for at least 12 weeks continuously or longer.
Coordination of services specifically for children/youth that have been in institutional level of care for one year or more. This service is available for the 180 calendar days prior to transition as well as the 60 calendar days following transition out of the institution/hospital. The service is billed upon the child's transition. Transitional coordination services provider will seek out children/youth who have long term institutionalization. This coordinator will work with institutional levels of care such as hospitals, nursing homes, etc. to determine the needs of the child/youth to be able to return to their home and community.

Coordination of services may include but is not limited to, housing, vehicle/environmental modifications, arrangements for medical equipment, parent/caregiver education/training, development of supportive services and caregiver supports, etc. The utilization of other Waiver services such as environmental/vehicle modifications or assisted technology and the supported service of Transitional Services is also supported.

For children/youth eligible for this service, focused attention and dedicated individuals/services are needed to address the barriers to return them back to their family/community. Traditionally, service access usually requires the potential member to be referred to services and then determined eligible and enrolled. Whereas this Transitional Service Coordinator will search for and identify appropriate children/youth that can be returned to their community and then referred to the Health Home for eligibility determination.

Transitional Care Coordination can be utilized for children/youth living in institutional settings, to identify and address barriers that prevent them from returning to their home and community. This service should be provided by the Transitional Service Coordinator, and a team of qualified individuals that can include, but is not limited to social workers, psychologists, care managers, nurses, pediatricians, etc.

Transitional Coordination is designed to assist the waiver participant/family to effectively manage transitioning to the community. It is an education and support service provided to a participant coping with the need to revise long term expectations, his/her changing roles, and the impact of these changes on him/her, family members and informal supports. The service is designed for individuals needing assistance in adjusting to a significant disability and living in the community. Prior to the termination of services a transition plan to the community will be implemented. Transition Coordination is used to assist the participant to become physically integrated into his/her environment

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The Health Home Care Manager will conduct the eligibility evaluation, develop the HCBS plan of care, and ensure that the child has a choice of HCBS providers after transition. The Transitional Service Coordinator cannot be the evaluator determining eligibility or ensuring choice of HCBS providers. Upon initiation of the service, as a transition service, the Transition Service Coordinator will work with the child and family to complete an initial transition plan. The transition plan indicates the proposed number of hours of service and justifies the need for the service. Goals must be reasonable and attainable and the transition should not extend beyond a 180 day period. Prior to the termination of services, a transition plan will be implemented. Services may be extended in extraordinary cases with sufficient justification and upon review and approval of the MCO or state staff.
For children/youth in facility and transitioning to the community; the Transition Service Coordinator can bill for up to 180 days while working with the child/youth while in an institution, however the billing is submitted and dated on the date of transition to the community. Billing cannot occur until the child is discharged. Once discharged, the Transitional Service Coordinator can bill for up to 60 days following transition to home/community, to ensure the child is stable at home. Agencies will serve participants who meet the established criteria for lengths or stay and who are able to be discharged

within 6 months with intensive care coordination. Agencies are expected to have connection and relationships with specific HHSC and or CMAs to connect to for eligibility and warm hand off at the time of discharge. All Transitional Care Coordinators will attend mandatory service transition training

This service does not duplicate other services available through the New York Medicaid State Plan. Once individual has been integrated into the community, the service will terminate. Upon initiation of the service, an initial transition plan must be completed and include specific goals. The provision of Transition Coordination under this waiver is cost effective and necessary to transition an individual from institutionalization. The cost effectiveness of this service is demonstrated in Appendix J.
Please note: It is the responsibility of the HCBS agency to ensure that staff providing services have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology).

It is the responsibility of the Care Manager to ensure that the HCBS providers developed service plan sufficiently outlines how the service being provided will address the participant's needs reach desired goals, and that the established Frequency/Scope/Duration is appropriate meeting all HCBS requirements to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology),
OR have made arrangements for an appropriately trained and knowledgeable individual to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Health and Human Service Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Care Coordination

Provider Category:

Agency

Provider Type:

Health and Human Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation

Review Team.
- Provider agencies and practitioners adhere to all Medicaid requirements.
- Provider agencies adhere to state cultural competency guidelines
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State prior to service delivery.
- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Individual Qualifications:
- Minimum qualifications of Persons employed as a Transition Coordinator must be a/an: Bachelor's degree with experience working with children/youth Training
- Mandated Reporter
- Personal Safety/ Safety In The Community
- Strength Based Approaches
- Suicide prevention training
- Domestic Violence Signs and Basic Interventions
- Trauma Informed Care
- Transition Training

Supervisor Qualifications:
- Minimum qualification of a Bachelor's degree with three years experience in human services. Preferred qualification of a Master's with one year experience in human services working with children/youth.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transitional Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute. Transitional Services (TS) are defined as individually designed services intended to assist a waiver participant in transitioning from a nursing home or institutional setting to living in the community. TS is requested by the Transitional Care Coordinator who is providing Transitional Care Coordination. TS is a one-time service. Per institutional discharge when working with a Transitional Care Coordinator and meeting the requirements for Transitional Care Coordination.

This supportive service of Transitional Services will be utilized when addressing the barriers that are preventing children/youth from returning home from an institutional setting. Transitional Services will allow funding for non-traditional waiver services usually for one-time for things such as rental assistance, basic needs and supplies, furniture, etc. related to the child/youth's complex healthcare needs.

If the waiver participant is discontinued from the program and re-enters the provider owned facility, they can access this service again upon discharge. This service is only provided when transitioning from a nursing home or other institutional setting such as a hospital. These funds are not available for moves from the participant's home in the community to another location in the community.

This service includes: the cost of moving furniture and other belongings; security deposits; broker's fees required to obtain a lease on an apartment or home; purchasing essential home furnishings; set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); and health and safety assurances such as pest removal, allergen control, or one time cleaning prior to occupancy, costs and/or fees associated with securing the service. Security deposits funded through this service and returned upon vacating the residence or dwelling must be returned to the TS provider. Upon return of the funds, the TS provider must submit a paid claim void to eMedNY. The service will not be used to purchase recreational items, such as televisions, DVD players,,music systems, or items of general utility that are not related to the child/youth's complex healthcare needs. Approved costs are covered by TS up to thirty (30) days prior to the individual's discharge from the nursing home into the community or no later than 60 days after discharge, if not duplicative of State Plan, other Waiver services, and demonstrated as connected to the discharge.. Reimbursement is one hundred percent (100%) of the approved cost.

All TS expenses must be included in the approved Initial Service Plan and provided and approved by an FMS /NYSDOH. Reimbursement is not provided for items purchased prior to approval. Transitional Services must be documented in the Service Plan and approved by FMS. The cost effectiveness of this service is demonstrated in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Maximum up to $8000 per qualifying institutional discharge. Transitional Services may be initiated up to 180 days prior to discharge from an institutional setting, but may not be billed until the child/youth is discharged.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transitional Services Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Services

Provider Category:

Agency

Provider Type:

Transitional Services Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

FMS verify the qualifications of Transitional Services vendor:
a. Must be familiar with the Transitional Services policies permitted in the waiver program as described in the program manual
b. Must be able to communicate well with all parties involved with the purchase of the services and any training needed, e.g. consumers, contractors, and local government officials.
c. Must be able to clearly describe in writing, and by design, the proposed purchase.
Must have knowledge of transition services appropriate for the child's needs

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee.

Frequency of Verification:

Initially and every 3 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service provides physical adaptations to the primary vehicle of the enrolled child which per the child's plan of care (POC) are identified as necessary to support the health, welfare and safety of the child or that enable the child to function with greater independence, including driver modifications for children who are obtaining their driver's license or have obtained their driver's license. The service is administered by a Financial Management Services (FMS) agency for billing purposes, even if this is the only self-directed service that the person accesses.

Service Components

Modifications include but not limited to: Portable electric/hydraulic and manual lifts, ramps, foot controls, wheelchair lock downs, deep dish steering wheel, spinner knobs, hand controls, parking break extension, replacement of roof with a fiberglass top, floor cut outs, extension of steering wheel column, raised door, repositioning of seats, wheelchair floor, dashboard adaptations, driver modifications, and other ancillary equipment or modifications necessary to guarantee full access to, and safety in, a motor vehicle.

The FMS secures a local contractor and/or evaluator qualified to complete the required work. In the case of vehicle modifications, the evaluators and modifiers are approved by National Mobility Equipment Dealers Association (NMEDA). Activities include and are not limited to determining the need for the service, the safety of the proposed modification, its expected benefit to the child, and the most cost effective approach to fulfill the child's need. The FMS contractor will be the provider of record for all members receiving V-Mods. The work is done by a contractor who is selected by the FMS. For Vehicle Modifications, the FMS is the provider of record for billing purposes. Services are only billed to Medicaid once the contract work is verified as complete and the amount billed is equal to the contract value. Vehicle Modifications are limited to the primary vehicle of the recipient.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the FMS and NYSDOH.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Vehicle Modifications are limited to the primary means of transportation for the child. The vehicle may be owned by the child or by a family member or non-relative who provides primary, consistent and ongoing transportation for the child. All equipment and technology used for entertainment is prohibited.

Other exclusions include the purchase, installation or maintenance of items such as cellular phones, global positioning/tracking devices, or other mobile communication devices; repair or replacement of modified equipment damaged or destroyed in an accident; alarm systems; auto loan payments, insurance coverage; costs related to obtaining a driver's license, title/registration, license plates, emergency road service, or rental vehicles when a vehicle modification is in process.

Repair & Replacement of modification: In most instances a specific type of Vehicle Modification is a one-time benefit to motor vehicles used by the child. Replacements, repairs, upgrades, or enhancements made to existing equipment will not be paid unless a defect or unforeseen issue determined by NYSDOH. In addition, if when the modification must be replaced or repaired, a depreciation schedule will be used to determine the limit of the amount to be applied to the cost.

Accessibility Modification Limits
Only those services not reimbursable under the Medicaid State Plan under 1905(a) of the Social Security Act or other federal/state funding streams will be reimbursable under the HCBS Waiver.
Vehicle passenger modifications have an established limit per service of $35,000 per year and vehicle driver modifications have an established limit per service of $65,000 per year. The limit cannot be exceeded without special circumstances, medical necessity documentation meeting specific NYSDOH requirements, and prior approval from FMS/NYSDOH. The FMS contractor must give prior approval for all vehicle modifications.

Note: driving itself is not justification for a medical necessity exception and driver modifications will not have a medical necessity exception. Any exception must have a clinical assessment that documents the functional need for the request and how it is the least costly option to meet the individual's needs. Vehicle Modifications may be initiated up to 180 days prior to discharge from an institutional setting, but may not be billed until the child/youth is discharged.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FMS

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Agency
Provider Type:
FMS
Provider Qualifications
License *(specify):*
Licensure appropriate to the trade
Certificate *(specify):*

Other Standard *(specify):*
FMS staff verify the qualifications of vehicle modification providers present the following knowledge and skills: h. Must be familiar with the vehicle modification policies permitted in the waiver program as described in state guidance; the FMS

should supply the evaluator with a copy of both prior to initiation of the evaluation.

Contractors performing any adaptation for a child in the waiver program is required to:
a. Be bonded;
b. Maintain adequate and appropriate licensure;

The National Mobility Equipment Dealers Association (NMEDA) verifies the credential of vehicle modification providers pursuant to NYF Fire Prevention and Billing Codes, 00 OMM/ADM 4.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS will verify vendor qualifications, DOH will verify FMS qualifications.

Frequency of Verification:

Provider qualifications are verified at the beginning of the vehicle modification contract by ACCES- VR.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☒ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☒ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Children receiving HCBS will be enrolled in and receive care management from the Health Home program authorized under the existing Health Home State Plan. Children enrolled in MMC or HIV SNPs who receive HCBS and choose not to enroll in Health Home care management will have HCBS Eligibility determinations and their Plan of Care (POC) completed by the State Designated Independent Entity and the MCO will provide monitoring and oversight of all plan covered services including HCBS. Children eligible for HCBS and Medicaid under Family of One will be assessed by the State Independent Entity to determine HCBS/Medicaid eligibility prior to being enrolled in Medicaid and a Health Home. Children who choose not to enroll in Health Home care management and receive HCBS and are in FFS will have HCBS Eligibility determinations and their POC completed by the State Designated Independent Entity who will also provide monitoring and oversight.

The Administrative function is limited to the LOC eligibility determinations for the non-Medicaid population. The state or the county Single Point of Access for mental health services will conduct LOC eligibility determinations for children who are not enrolled in Medicaid. Upon determining eligibility and establishing Medicaid coverage, the care coordination function will transition to the health home (or one of their contracted care management agencies) of the member's choice for development of the plan of care and other ongoing case management functions.
Health homes will provide the 4 core case management services: Eligibility Evaluation/Needs Assessment; Plan of Care development, Referral to services, and Monitoring.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

In accordance with Section 2899-a of the Public Health Law any entity that provides home and community based services (HCBS) to enrollees who are under twenty-one years of age under a demonstration program pursuant to section 1115 of the federal social security act must request a criminal history record check, by the New York State Department of Health (NYSDOH) and the New York State Division of Criminal Justice Services for each prospective employee who will provide HCBS services to such enrollees.
Note: this program will operate concurrently with the State's 1115 MRT waiver.

The term "employee" does not include persons licensed pursuant to Title 8 of the Education Law or Article 28-D of the Public Health Law, provided that such persons are operating within their Title, meaning that such license was required for the position. Volunteers are not subject to this requirement. Part 402 of Title 10 of the Official Compilation of Codes, Rules and Regulations for the State of New York (NYCRR) Part 402 establishes the process for conducting the criminal history record checks and the standards for review by NYSDOH. Each provider must develop and implement written policies and procedures that include protecting the safety of persons receiving services from temporary employees consistent with the NYS statutory requirements and regulations (e.g., appropriate direct observation and evaluation).

Criminal history record checks are finger print-based, national Federal Bureau of Investigation (FBI) criminal history record checks, which require the prospective employee's fingerprints, accompanied by two forms of identification, for submission. Providers must maintain and retain current records, including a roster of current employees who were reviewed, to which NYSDOH shall have immediate and unrestricted access to the determination letters for the purpose of monitoring compliance with these provisions.

Verification of compliance with the criminal history record check regulations is an element of the NYSDOH surveillance process. At the time of surveillance, NYSDOH surveyors utilize a standardized tool to evaluate compliance with the criminal history background record check requirements. If a provider is found not to be in compliance, a statement of deficiency(ies) is issued, and the provider has to provide a plan of correction. The surveillance process is the State's annual on-site review audit process for MCOs. At the time of the surveillance on-site review, NYSDOH surveyors utilize a standardized tool to evaluate compliance with the criminal history background record check requirements. If a provider is found not to be in compliance, a statement of deficiency(ies) is issued, and the provider has to provide a plan of correction.

Those providers that are transitioning to become Health Homes will be subject to regular auditing to ensure compliance with these and other requirements, as part of the affiliated Lead Health Home's redesignation process, which occurs at least every three years.
Those providers that will not be transitioning to become Health Home CMAs, but rather will continue as service providers, will be subject to the provider qualification monitoring process as outlined in each service description.

Criminal History Record Checks (CHRC) are finger print-based, national Federal Bureau of Investigation (FBI) checks that cover all unsuppressed criminal history records from NYS DCJS and a national check from the FBI. The records, in many cases, go further back than age 18. Especially where the individual was tried as an adult or adjudicated a juvenile delinquent (JD). Some matters, that are civil in nature, such as Family Court proceedings and Immigration matters, are suppressed and we do not receive records regarding these cases. Providers of Home and Community Based Services (HCBS) to children under 21 years of age authorized under the Children's 1915 (c) Waiver amendment will be subject to this requirement upon approval of this waiver amendment.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS

upon request through the Medicaid agency or the operating agency (if applicable):

New York State requires that individuals applying to certain positions be checked against the Statewide Central Register prior to working with children. As per Section 424a of the Social Services Law, it is ultimately the responsibility of the provider agency to:
• Determine who has regular and substantial contact with children (employees, prospective employees, consultants, contractors and volunteers) within the agency;
• To contact the Statewide Central Register; and
• To receive and handle the response from the Statewide Central Register. Each provider develops its own procedures to ensure compliance.

The New York State Office of Children and Family Services maintains the Statewide Central Register of Child Abuse and Maltreatment (SCR, also known as the "hotline") for reports made pursuant to Section 424a of the Social Services Law. The SCR receives telephone calls alleging child abuse or maltreatment within New York State. SCR staff relay information from the calls to the local CPS for investigation, monitors their prompt response, and identifies whether there are prior child abuse or maltreatment reports. The SCR receives calls 24 hours a day, every day from two types of sources: persons who are required by law (mandated) to report suspected cases of child abuse and maltreatment; and calls from non-mandated reporters, including the public.
- The type of staff for whom abuse registry screenings must be conducted: Any HCBS provider employee who has regular and substantial contact with children (employees, prospective employees, consultants, contractors and volunteers) within the designated waiver agency, ultimately the agency is responsible to determine what "substantial contact" means and who is subject to the screening.
- The entity or entities responsible for conducting the screening against the registry: Each provider agency is responsible for conducting the screening against the registry
The state process for ensuring that mandatory screenings have been conducted: DOH is the responsible party. DOH has a provider designation process where it has an MOU with the licensure agencies who perform limited activities for DOH including verification that mandatory screenings occurred as part of their licensure monitoring and report any and all issues to DOH. DOH through its record reviews or designees will review to ensure that each provider agency has conducted the screening for any HCBS provider employee who has regular and substantial contact with children. The screening is conducted against the registry maintained by the New York State Office of Children and Family Services called the Statewide Central Register of Child Abuse and Maltreatment (SCR, also known as the "hotline") for reports made pursuant to Section 424a of the Social Services Law. Compliance with this requirement will be reviewed as part of the redesignation process, which will occur at least every three years.
- Method to monitor this process on a yearly basis due to the rate of turnover in staffing: compliance with this requirement will be reviewed annually and as part of the redesignation process, which will occur at least every three years.
- Method used to conduct the reviews: part of the provider validation redesignation reviews that occur at least every 3 years.
- Consequences if a provider is found to be out of compliance: The remediation process is initiated when the MCO/HH or NYSDOH staff or Interagency Monitoring Team identifies a lack in the quality of provided services or any other issue related to administration of waiver services including the qualifications and training of a practitioner/provider agency such as lack of compliance with screening requirements. In such situations, the standard procedure is for NYSDOH staff, Interagency Monitoring Team, and MCO to discuss the situation and for NYSDOH to issue a statement of deficiency(ies). The provider must provide a plan of correction. NYSDOH staff, the IMT and MCO may collaboratively work with the provider to develop a plan of correction, if necessary. Implementation of and compliance with the plan of correction are monitored by NYSDOH and MCO.

If the plan of correction requires a change in the participant's service, NYSDOH staff and the MCO will work cooperatively to address the service deficiency and when necessary, transition the child to another waiver provider. The HHCM will communicate any changes needed to the family and help the family find alternative providers. To ensure continuity of service during the transition period, the original provider will be required to transfer the participant case records and other pertinent documents to the new provider until transition is complete.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide waiver services. The provider may be referred to the licensure or certification agency staff, as needed. Accordingly, NYSDOH staff, or its designee the IMT, will issue a letter to the provider terminating the provider's waiver designation provider status.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

- ◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ◉ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

NYSDOH maintains an open enrollment process for entities who are designated as meeting the HCBS provider qualifications as a Children's Medicaid waiver provider. NYSDOH has a multi-level process in conjunction with New York State licensing and certification agencies (OPWDD, OMH, OASAS, and OCFS) for assuring that the providers that serve waiver participants are qualified. Beginning April 1, 2019, providers of the following services must be designated to provide newly aligned Children´s HCBS services under the NYS Medicaid program (both fee–for–service Medicaid and Medicaid Managed Care): HCBS: Caregiver/Family Advocacy and Support Services, Respite, Supported Employment, Day Habilitation, Community Habilitation, Palliative Care-Counseling and Support Service, Palliative Care Massage Therapy, Palliative Care Expressive Therapy, Palliative Care Pain & Symptom Management, Prevocational Services and FMS. The remaining services (adaptive and assistive technology, vehicle modifications, environmental modifications, are purchased goods where the vendor is not enrolled in Medicaid and the FMS is the provider of record. Staff will review the potential new agency's background and program qualifications to ensure the agency has the requisite knowledge and skills to provide the service(s) it proposes to provide. Included in this review is a check of the agency's Medicaid provider enrollment information, a comprehensive review of the agency's history, including their relevant experience with children with physical and/or developmental disabilities. The provider must submit an application to NYSDOH or its designee demonstrating compliance with the qualifications and competencies necessary to meet waiver participant needs. In addition, every provider of services must complete the eMedNY provider enrollment process to verify that it meets all federal and State requirements for Medicaid participation. Information is available to all potential providers on the DOH website with direct references to the Children's HCBS provider application or the eMedNY website. These websites explain the process and qualifications for the waiver services. Providers may also contact DOH staff or its designee for further information.

In order to ensure the highest level of accessibility and availability of care management and HCBS services possible, we allow any willing and qualified provider to apply for designation/Medicaid enrollment for care management and/or HCBS. However, whenever a Health Home or their contracted Care Management Agencies (CMAs) acts as an HCBS service provider or is affiliated with an HCBS service provider, the Health Home or CMA will not be permitted to provide care management and direct services to the same child, unless they have been determined by the DOH to be the only willing and qualified provider in the area

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

○ **No, the state does not choose the option to provide HCBS in acute care hospitals.**

○ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*

☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**

☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**

☐ **The HCBS must be identified in the individual's person-centered service plan; and**

☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

And specify: **(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver providers who meet designation, licensure, and certification requirements and adhere to other standards continuously prior to furnishing waiver services (N Number of waiver providers who meet designation, licensure, and certification requirements and adhere to other standards continuously prior to furnishing waiver services/D Total waiver providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Designation Files; MCO Credentialing Files

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency designee (NYSTEC)	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver providers who meet designation, licensure, and certification requirements and adhere to other standards prior to furnishing waiver services initially (N Number of waiver providers who meet designation, licensure, and certification requirements and adhere to other standards prior to furnishing waiver services initially/D Total waiver providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Designation Files; FFS Claim & MC Encounter Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of non-licensed/non-certified providers of waiver services who adhere to waiver requirements (N Number of non- licensed/non-certified providers

who adhere to waiver requirements / D Total non-licensed/non-certified providers re-designated or designated during the WY)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver provider requirements verification records

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of licensed/certified providers of waiver services verified that provider training is conducted in accordance with state requirements and the approved waiver(N # of licensed/certified providers verified that provider training is conducted in accordance with state requirements and the approved waiver/D Total licensed/certified providers re-designated or designated during the WY)

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
 # and % of non-licensed/non-cert providers of waiver services verified that provider training is conducted in accordance with state requirements and the approved waiver (N # of non-licensed/non-cert providers verified that provider training is conducted in accordance with state requirements and the approved waiver/D Total non-licensed/non-cert providers re-designated or designated during the WY)

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The remediation process is initiated when the MCO/HH or NYSDOH staff or Interagency Monitoring Team identifies a lack in the quality of provided services or any other issue related to administration of waiver services including the qualifications and training of a practitioner/provider agency.

In such situations, the standard procedure is for NYSDOH staff, MCO and Interagency Monitoring Team to discuss the situation and for NYSDOH to issue a statement of deficiency(ies). The provider must provide a plan of correction. NYSDOH staff, MCO and the IMT may collaboratively work with the provider to develop a plan of correction, if necessary. Implementation of and compliance with the plan of correction are monitored by NYSDOH and MCO.

If the plan of correction requires a change in the participant’s service, NYSDOH staff and MCO will work cooperatively to address the service deficiency and when necessary, transition the child to another waiver provider. The HHCM will communicate any changes needed to the family and help the family find alternative providers. To ensure continuity of service during the transition period, the original provider will be required to transfer the participant case records and other pertinent documents to the new provider until transition is complete.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide waiver services. The provider may be referred to the licensure or certification agency staff, as needed. Accordingly, NYSDOH staff, or its designee the IMT, will issue a letter to the provider terminating the provider's waiver designation provider status.

After 3/1/2024, the FMS responsible for providing FMS services will identify unsatisfactory vehicle modification, home modification, adaptive and assistive technology, and transitional services (effective 1/1/2026) contractors. The FMS will disqualify unsatisfactory contractors and will find alternate contractors when necessary. The HHCM will help the family find alternate contractors. Unsatisfactory accessibility modification and adaptive and assistive technology contractors will be notified of their disqualification from further service by the administering MCO, FMS, or DDRO and LDSS (through the transition

Documentation of remediation activities is accomplished by the following measures: correspondence among NYSDOH waiver management staff, MCO staff, the CM, participants' and their parents/legal guardians, and/or service providers; amended plans of care; case reviews and reports of follow-up meetings with participants and their families documented by MCO and HH; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file. Circumstances involving remediation are maintained, as appropriate, by NYSDOH and/or the MCO.

NYSDOH will initially verify provider designation status through the web-based online portal system, assuring providers are approved and active, before they are authorized to provide Wavier services. The MCO is also responsible for verifying the status of each Waiver services providers through their credentialing processes. The Plan will maintain up-to-date credentialing files for all Waiver services providers. Provider designation will be reverified at least every three years by NYSDOH or its designee.

NYSDOH issues guidance to all Waiver services providers regarding required trainings through the HCBS Provider Services Manual. Individual waiver service practitioners are required to complete training on the required topic areas before they are qualified to begin providing direct Waiver services to participants. Waiver service providers are required to maintain training records on all staff and verify training had been completed before the staff can initiate service provision. The records are required to be made available to the NYSDOH or its designee at the time of site visits for compliance review.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☒ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Prior to any HCBS delivery, the HCBS provider must receive a referral from the participant's HH care manager. The HCBS provider will then evaluate the referral for appropriateness prior to delivery of any HCBS. After determining appropriateness, the HCBS provider can provide HCBS for the Initial Service Period beginning on the first date of billable service for the participant and is service specific. The Initial Service Period is the period of time after accepting an HCBS referral but prior to submitting an HCBS Authorization Request lasting up to 96 units/24 hours or 60 days (whichever comes first). The Initial Service Period is used to complete an intake assessment, to finalize service goals and objectives, and determine Frequency/Scope/Duration (F/S/D) for the service. Services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM which clearly indicates the participant's assessed needs and goals and must be necessary to assist a waiver participant to avoid institutionalization and function in the community. If the service is needed beyond the Initial Service Period, an HCBS approved Authorization is needed.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

a. List all HCBS settings:

1. Setting(s): HCBS recipients choose where services will be provided. Services are provided in the community and/or the participant's home.
a. HCBS: Community Habilitation, Day Habilitation, Caregiver/Family Advocacy and Support Services, Planned Respite, Crisis Respite, Prevocational Services, Supported Employment, Palliative Care – Expressive Therapy, Palliative Care – Massage Therapy, Palliative Care – Counseling and Support Services, Palliative Care – Pain and Symptom Management
1. 2. Setting(s): Residential Respite located in buildings integrated into the community
a. HCBS: Planned Respite, Planned Overnight Respite, Crisis Respite, and Crisis Overnight Respite
1. 3. Setting(s): Provider's multiuse agency building which may be a standalone, community integrated building run by non- profits, an office in a commercial building, and/or multipurpose, community integrated state or county run buildings.
a. HCBS: Community Habilitation, Day Habilitation, Caregiver/Family Advocacy and Support Services, Planned Respite, Crisis Respite, Prevocational Services, Supported Employment, Palliative Care – Expressive Therapy, Palliative Care – Massage Therapy, Palliative Care – Bereavement Services, Palliative Care – Pain and Symptom Management

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

Method of initial settings compliance determination:

To validate compliance for all categories of settings, the 1915(c) Children's Waiver (CW) team employed a standardized process to conduct reviews and determine compliance for all designated residential and non-residential settings overseen by the CW.

o First, the CW Team reviewed the address of each designated Children's HCBS provider site using Google Maps to visually search for proximity to location in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or location in a building on the grounds of, or immediately adjacent to, a public institution. An additional Google search was performed for each address to ensure that search results did not also yield results for those settings that do not meet the definition of being home and community-based, such as a nursing facility, institution for mental diseases, intermediate care facility for individuals with developmental disabilities, a hospital, and/or residential treatment facility. All designated providers and addresses were also compared against State Agency lists to further ensure that no providers were operating out of a restricted setting. These initial determinations were further validated during the virtual onsite review where reviewers requested to observe via video conferencing all aspects of the sites, both inside and outside, to verify that the sites were not restrictive/isolating settings. Photos and videos of the settings were taken to support the reviewers' observations.

o Next, provider self-assessment surveys, developed based on CMS guidance "Exploratory Questions to Assist State's in the Assessment of Residential [and Non-Residential] Settings," were sent to all designated CW HCBS providers via the Survey Monkey tool. The CW Team hosted an informational webinar prior to disseminating the survey to walk through the entire compliance review process and answer provider's questions. The CW Team also discussed the provider self-assessment during monthly meetings with CW HCBS providers to provide information, collect stakeholder input and answer questions. Providers were instructed to complete one survey for each location (site) where they are designated to provide CW HCBS.

o After receiving a 100% response rate to the surveys, the CW Team analyzed all responses and flagged initial instances where follow-up would be indicated, particularly those responses that indicated potential non-compliance.

o To validate the survey responses, the CW Team instructed providers to submit documentation for each designated CW HCBS site. In much the same manner as educating providers about the provider self-assessment process, the CW Team hosted an informational webinar to walk through the provider documentation tool, the types of documentation required for submission, and fielded provider questions.

o Documentation was requested for each HCBS Final Rule standard; examples of applicable documentation were provided, including but not limited to, policies, procedures, and other forms of supporting documentation that demonstrates compliance with HCBS Final Rule standards.

o After reviewing each site's self-assessment and documentation submission, the CW conducted virtual onsite reviews to further validate the provider self-assessment responses and contents of provider documentation.

• All providers received an agenda that outlined the onsite review process and expectations prior to each site review. In many instances, a portion of the virtual onsite reviews was devoted to discussing elements of the submitted documentation that were unclear and instances of lack of alignment between the provider self-assessment survey responses and the submitted documentation. During these reviews, the CW Team also provided instructional guidance as to how providers can come into compliance. As part of the site review, the CW Team conducted interviews with provider representatives (administration and staff) to understand how the program/residence is structured.

• Whenever possible, children/youth and/or families/caregivers were either involved in an interview portion of the onsite review or were sent a participant survey to further ensure that all standards were being met. The CW Team conducted interviews with children/youth and/or families/caregivers without program staff present to ensure children/youth and/or families/caregivers could speak freely regarding the services received.

• Reviewers also conducted interviews with at least one program staff to establish if the setting has the effect of isolating individuals receiving CW HCBS from the broader community and determining compliance with all applicable standards.

o The findings for all designated CW HCBS settings are depicted below. The total number of sites also includes sites that have since de-designated since the review process concluded.

• # Sites that Cannot Comply with Final Rule 0
• # Sites that Could Come into Full Compliance (200 total)
o Residential Settings (Planned Overnight Respite and Crisis Overnight Respite) – 6
o Home and Community-Based ONLY Settings (All HCBS) - 66
o Both Onsite setting AND Home and/or Community-Based Settings (All HCBS) - 128

- # Sites that are Presumptively Institutional in Nature (i.e., Heightened Scrutiny) (3 total)
  - Residential Settings (Planned Overnight Respite and Crisis Overnight Respite) – 3*

After a review of self-reported data submitted by survey, site assessment data of a statistically representative sample (sample size of 100, with 95% confidence interval), and review of documentation submitted by all CW HCBS providers (i.e., policies and procedures), three CW HCBS residential sites, operated by the same provider (Martin de Porres), were identified as Prong 3 (settings having the effect of isolating individuals receiving Medicaid HCBS services from the broader community).

The CW Team took following steps for all sites identified for Heightened Scrutiny:

- In collaboration with OCFS, the CW Team reviewed virtual site assessment findings report with provider, including remediation next steps to become compliant with the HCBS Final Rule (August 2021).
- The provider agency mentioned above addressed Prong 3 findings by ceasing to provide CW HCBS to children/youth residing at all three sites (August 2021).
- The provider agency shifted their model to provide CW HCBS to children/youth who reside in the community, at a home and/or community setting of the child/youth's choosing and not in the agency's residential program (September 2021). Agency submitted documentation to support their CW HCBS's program's redesign (October 2021, updated February 2022).
- Eligible children/youth previously receiving CW HCBS were assessed and determined that Children and Family Treatment and Support Services (CFTSS) would meet their service goals and needs (August 2021).
- The CW Team and the provider agency collaborated to confirm the CW HCBS that residents were receiving would be covered through all service provision in the residential program and the CFTSS program (August 2021).
- The CW Team and HCBS Final Rule Lead confirmed with CMS that reporting of these Heightened Scrutiny settings could be done as part of New York's Statewide Transition Plan (STP) and did not require individual evidence packets to be put out for a separate public comment process (January 2022).

After site reviews were completed, "Review Findings/Remediation Reports" were drafted for each provider/site that described a comprehensive account of the findings and overall compliance determination based on the provider self-assessment responses, submitted documentation, and the virtual onsite review. The Review Findings/Remediation Reports detailed the findings of HCBS Final Rule standards and determined whether the provider/site was in compliance for each standard by noting whether 1) no action was needed (fully compliant) 2) action was recommended, or 3) corrective action/remediation was required. The CW Team detailed next steps and guidance in Review Findings/Remediation Reports for instances where corrective action/remediation was required and/or recommended for the provider/site to be determined compliant with the HCBS Final Rule. Providers were required to return a signed copy of the Findings/Remediation Reports acknowledging receipt and understanding of the contents of the report and corrective actions, if applicable. Provider/sites were given one month to address any necessary corrective actions/remediations and provide additional/updated documentation.

Additional/updated documentation submitted by providers in response to corrective actions was reviewed and tracked. A Corrective Action Addendum to the Findings/Remediation Report was drafted to detail whether the provider/site was in compliance for each standard where a remediation was indicated in the Findings/Remediation Reports by noting whether 1) no action was needed (fully compliant) 2) action was recommended, or 3) corrective action/remediation was required. If the submitted documentation did not fully satisfy the corrective actions, the CW Team again provided next steps/guidance for those standards still not in compliance. This Corrective Action Addendum process was conducted until the provider/site came into full compliance with all standards. The CW Team offered additional support should the provider/site have any outstanding questions or need clarification.

b. Description of how on-going compliance is determined including how individuals in their homes are free from coercion or restraint:

The CW Team will continue to monitor providers' compliance with the HCBS Final Rule on an ongoing basis. Ongoing monitoring of compliance with the HCBS Final Rule will be included in the CW HCBS case record review process, which is conducted on a yearly basis. A HCBS Final Rule attestation component will also be added into the CW Team's current attestation survey where providers attest to compliance with background checks, education, and training. CW HCBS providers will be required to sign the attestation and attest to compliance with all HCBS Final Rule standards, including but not limited to compliance with person-centered planning every year and every three years during CW's redesignation process. Additionally, participants will be periodically surveyed for satisfaction with CW HCBS service delivery and ensuring services are delivered in a person-centered and community integrated manner. The processes described here apply to all CW HCBS setting types.

Since providers may elect to become designated CW HCBS providers on a rolling basis, post-March 2023, the CW Team

will continue to conduct HCBS Final Rule compliance reviews for all newly designated CW HCBS providers following the process described in the Site Validation section.
For private homes or apartments owned or rented where children/youth live with family/caregivers, the CW Team will continue to ensure that HCBS Final Rule standards are followed through the monitoring processes described in this section to ensure that CW HCBS providers are following principles of person-centered planning and delivering services in a participant-driven manner, which is part of the yearly case review. If the CW team finds during monitoring that a CW participant is living with an unrelated paid caregiver, then the additional provider-owned and controlled settings standards and the full site assessment process, described in response to question 21(a), above, apply. Should services be delivered to a CW HCBS participant in a manner inconsistent with person-centered planning, the State has several incident reporting processes and mechanisms to guard against coercion and abuse, which are outlined in the Beneficiary Recourse section. Further, children/youth and/or families/caregivers are provided CW HCBS Participants Rights at the onset of services by the Health Home Care Manager, which outlines the rights of a CW HCBS participants and provides information regarding courses of action to take if those rights are not being upheld. The Health Home Care Manager must communicate with children/youth and/or the family/caregiver at

least once each month and will assess whether these rights are being upheld.

The Health Home Care Manager (HHCM) is responsible for detecting critical incidents such as coercion and unauthorized use of restraints and/or seclusion through face-to-face visits, routine contacts with the participants, and possibly through complaints/grievances or incident reporting. The HHCM are responsible for the overseeing the waiver participants and assuring their health, safety, and welfare. HHCM regularly monitor participant health and welfare during in-person contact performed according to the child's acuity and the HH contact schedule. HHCM and HCBS providers are mandated reporters for child abuse to the New York Statewide Central Register of Child Abuse and Maltreatment. The HHCM takes reports about use of restraint or seclusion from parents or other staff and reports to New York Statewide Central Register of Child Abuse and Maltreatment.

MCO: The majority of children will be served by MCOs who are mandated to maintain critical incident identification, tracking and resolution processes including identification of coercion or restraint. In the children's plan standards requirements, MCOs are required to separately track critical incident reporting related to children's populations and service covered for children including HCBS services under this waiver. The MCO must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its Enrollees in receipt of Long-Term Services and Supports on a continuous basis. Such mechanisms will include, at a minimum: i) A process to include information in education materials distributed to Enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for Enrollee assistance; ii) provisions in subcontracts to ensure providers of long term services and supports comply with State requirements for worker criminal background checks; iii) identification of critical incidents, including but not limited to: wrongful death, restraints, and medication errors resulting in injury, which are brought to the MCO's attention, and subsequent investigation or referral of the incidents to oversight agencies; and iv) reporting critical incidents to NYSDOH. All MCO clinical staff must be trained on reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances, foster care) within 30 days of hire. All MCOs must provide a report of critical incidents identified and/or investigated by the Contractor involving Enrollees in receipt of long term services and supports. The report goes to SDOH on a quarterly basis, in a manner and format determined by SDOH.

c. Information on the state's ongoing monitoring process:
HCBS Final Rule compliant person-centered planning will be monitored for compliance across all settings described in the introduction, including through yearly case record reviews and the grievance and complaint reporting processes when person- centered planning principles are not followed. Further, a section specific to compliance with person-centered planning will be added to the attestation. CW HCBS providers are required to maintain documentation that describes how person-centered planning is executed, and staff are required to be trained in principles of person-centered planning. The State maintains a person- centered planning online resource library and encourages providers to leverage the training and resources contained on this site Since the CW Team confirmed that all CW HCBS providers in all settings have reintegrated participants into the community, future verification will be managed through the standard ongoing monitoring process as described above.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☒ **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.** ***(see Appendix D-1-d-ii)***

☒ **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.**

☒ **Home and community-based settings do not include 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.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

◉ **No, the waiver does not include provider-owned or controlled settings.**

○ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☐ **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.**

☐ **Each individual has privacy in their sleeping or living unit:**

- ☐ **Units have entrance doors lockable by the individual.**
- ☐ **Only appropriate staff have keys to unit entrance 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.**

☐ **Individuals have the freedom and support to control their own schedules and activities.**

☐ **Individuals have access to food at any time.**

☐ **Individuals are able to have visitors of their choosing at any time.**

☐ **The setting is physically accessible to the individual.**

☐ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Plan of Care (POC)

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-

centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

A Care Manager in the State of New York is employed by a Health Home (HHCM) OR by a Care Management Agency (CMA) who is contracted to provide care management for the Health Home through a Business Associate Agreement.

A Health Home Care Manager (HHCM) must attend a training (online or in-person) and complete a certification exam with a minimum reliability score of 0.70 (online).

In addition, an HHCM must have the experience required to meet the care planning needs of the child as determined by, but not limited to, acuity (as measured by the CANS-NY, and/or the children's overall needs), presence of a single qualifying or co-occurring conditions, including Serious Emotional Disturbance, Complex Trauma, co-occurring medical or co-morbid conditions. Staff qualifications for care managers that serve children with an acuity level of "high" as determined by the CANS-NY are:
• A Bachelors of Arts or Science with two years of relevant experience, or
• A License as a Registered Nurse with two years of relevant experience, or
• A Masters with one year of relevant experience.

For children with a high acuity that are enrolled in the Early Intervention Program and receiving Health Home services through a provider approved under the Early Intervention Program, the minimum qualifications for EIP service coordinators set forth in Section 69-4.4 of 10 NYCRR will apply. Those qualifications are a minimum of one of the following educational or service coordination experience credentials:
i. two years of experience in service coordination activities as delineated in this Subpart (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or
ii. one year of service coordination experience and an additional year of experience in a service setting with infants and toddlers with developmental delays or disabilities; or
iii. one year of service coordination experience and an Associates degree in a health or human service field; or
iv. a Bachelors degree in a health or human service field. Demonstrated knowledge and understanding in the following areas:
i. infants and toddlers who may be eligible for early intervention services;
ii. State and federal laws and regulations pertaining to the Early Intervention Program;
iii. principles of family centered services;
iv. the nature and scope of services available under the Early Intervention Program and the system of payments for services in the State; and
v. other pertinent information.

The Children's Waiver, Health Home case management complies with all federal Conflict of Interest (COI) requirements for the 1915(c) waiver authority.

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

Whenever a Health Home or their contracted CMAs acts as an HCBS service provider or is affiliated with an HCBS service provider, the Health Home or CMA will not be permitted to provide care management and direct services to the same child, unless they are the only willing and qualified provider in the area (we will consider geographic location, cultural needs and linguistic needs in making this determination). We will explain how we determine whether any provider who is providing both care management and HCBS is the only willing and available provider.

• In order to ensure the highest level of accessibility and availability of care management and HCBS services possible, we allow any willing and qualified provider to apply for designation/Medicaid enrollment for care management and/or HCBS. However, no provider is permitted to provide care management and HCBS to the same individual, unless it is determined that either the care management agency or the HCBS provider is the only willing and available provider based on established criteria:
• Linguistic, cultural, geographic factors would apply as the criteria. Rural restrictions.
• Access is not a criteria for determining only willing provider, but we can include some type of capacity assessment.
• We will have to establish an “only willing provider process” and ensure that children are not receiving both services from the same entity unless this criteria have been met.
• In such cases where the same provider, or an affiliated provider is the only willing and available provider, the care manager will be required to provide Freedom of Choice information to the member, provide information about dispute resolution options to the member. These providers will be required to adhere to conflict of interest assurances, as outlined below.

Conflict of interest assurances and how they are enforced
• Each HCBS Provider, Health Home and their contracted Care Management Agencies (CMAs) who is approved to provide both care management and Children’s Waiver HCBS will maintain a conflict-of-interest policy which will be reviewed by NYSDOH for alignment with 441.301(c)(1)(vi) during provider designation reviews.
• On the policy, HCBS Providers, Health Homes and their contracted CMAs will be required to disclose all lines of business and affiliations with other service providers or any other relationships which may give rise to an actual or apparent conflict of interest
• Health Homes and their contracted CMAs will continue to provide information about freedom of choice and dispute resolution options to members as they currently do under our conflict-free policy
• NYSDOH will require Health Homes and their contracted CMAs to review and update their affiliations and conflict of interest policy at least annually and will review safeguards and firewalls on an annual basis. This expands upon existing requirements for NY Medicaid providers which is collected through the Provider Enrollment process.
• Any provider who engages in both care management and HCBS functions will be subject to closer monitoring for compliance with conflict of interest assurances.
• NYSDOH will continue to require HCBS providers, Health Homes and their contracted CMAs to report all lines of business and affiliations and will review them for potential conflicts of interest, upon application and during routine provider reviews. NYSDOH will maintain a list for reference and ease of access of all Health Homes and their contracted Care Management Agencies and all of their affiliations and lines of business. “Affiliations” will be determined to exist whenever there is an overlap in ownership or control between two entities.
o These providers will be required to create and maintain firewalls between key functions to ensure that there the individuals employed by the care management agency who develop the plan of care are completed separated from individuals employed by the entity or affiliate who provide HCBS services. This requires physical separation, different supervision, separate oversight and other distinctions and firewalls as necessary, in accordance with conflict-of-interest assurances identified in the 1915c application.
o NYSDOH will continue to review claims data periodically to identify any patterns which indicate improper self-referral or possible infringements on freedom of choice.
o The routine case records and claims data review will include regular policies and procedures review process as well as updated annual disclosure attestation for HCBS providers, Health Homes, and their CMAs to reported all lines of business and affiliations to ensure compliance with these requirements. A new process will be developed through the HCBS designation process and working with lead Health Homes when onboarding new CMAs, to address an potential conflicts and potentially prohibit those applying HCBS providers or CMAs for designation of a new line of business.
o The Conflict-Free policy aligns with the waiver amendment.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a*

process in place to ensure:

☒ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☒ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☒ **Direct oversight of the process or periodic evaluation by a state agency;**

☒ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☒ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Safeguards
The 1915(c) will ensure choice of Case manager (between HHCMs). The Children's Waiver Health Home will comply case management comply with all federal Conflict of Interest (COI) requirements for the 1915(c) waiver authority. The HH will:
- Full disclosure to participants if a CMA also provides direct services,
- Participants will have freedom of choice of Health Home providers with the MCO controlling the participant choice process,
- Participants will be provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development,
- Children will have a clear and accessible grievance and appeal process as well as an alternative dispute resolution process;
- The provider agency that develops the person-centered service plan must administratively separate the plan development function from the direct service provider functions. Specifically, Health Homes that provide care management and direct services must ensure that the provider providing care management is not the same as the provider providing direct care services and that these individuals are under different supervisory structures.
- Health Home care managers are restricted from assessing a person for whom they have financial interest or other existing relationship that would present conflict of interest.
- DOH will conduct annual case record reviews to ensure that participants have been informed of their rights, have had an assessment of risk, full information about availability of provider choice, services, frequency and duration
DOH will provide periodic evaluation of each Health Home to assure that Care Management Agencies that are also a direct service provider comply with the safeguards above.

The parents/legal guardians, along with the waiver applicant/participant as appropriate, actively participate in the development of the plan of care and selection of service providers and lead the person-centered planning process where possible. The parents/legal guardians, along with the waiver applicant/participant as appropriate, may include people chosen by them. The person-centered planning process will be timely and occur at times and locations of convenience to the parents/legal guardians and the waiver applicant/participant, as appropriate.

Upon application, the HHCM is responsible for providing the applicant's parent(s)/legal guardian(s) with information about waiver eligibility and enrollment criteria, and the various options for service. The applicant's parents/legal guardians are informed of their choice of system of care; institutionalization or community based waiver program, as well as the choice of available waiver services and waiver service providers. The parents/legal guardians of waiver participants must sign a Freedom of Choice Form that is witnessed and dated, indicating their decision to enroll the child in the Children's waiver program. The parents/legal guardians also sign the Choice of Case Management/Provider Selection form, indicating their choice of HH and waiver providers for their child. A copy of each of these forms is given to the parent and maintained in HH. Each HH has a list of available waiver providers that is shared with the participants and their parent(s)/legal guardians.

The waiver participant/participant's parent or legal guardian are assured certain rights, and must agree to certain responsibilities related to the waiver program. Once the participant/parent/legal guardian chooses the HHCM, the HHCM is responsible to work with the participant/parent/legal guardian continuously to:

• Provide an explanation of all services available to the child in the Children's waiver that may benefit the child. This information includes range of services offered through the waiver to prevent placement in skilled nursing facility, hospital or ICF/IID
• Provide assistance reviewing and understanding waiver material.
• Provide the opportunity to participant/parent/legal guardian to participate in the development, review, and approval of all POC meetings, including any change which ensures that the participant/parent/legal guardian has an active role in the POC development. The POC reflects all services to be provided to the participant including service type, frequency and duration. The POC is signed by the parent/legal guardian verifying that they have participated in the development of the POC.
• Provide the participant/parent/legal guardian choice of their child's service providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Introduction
The HHCM is the primary contact with NYSDOH staff, MCOs, and family of the applicant/participant. The MCOs will frequently communicate with service providers and HHCM. HHCM has the responsibility for ensuring that the plan for waiver services, referred to as the Plan of Care, is developed in accordance with waiver policy and protocols. For HH members, the HCBS is integrated into the Health Home comprehensive plan of care

Eligibility Evaluation/Assessment
The person centered planning process begins with the eligibility evaluation that includes the use of a portion of the CANS-NY assessment tool (for NF and Hospital LOC) or the OPWDD ICF-IID tool that documents the applicant's needs, and determination that the applicant needs skilled nursing facility, ICF/IID or hospital level of care as required for participation in waiver. If the participant is a member of a Health Home, the HHCM performs a complete CANS-NY assessment on the child. A complete CANS-NY is not necessarily conducted for individuals not in Health Home. The state staff conducts the eligibility evaluation for individuals who are not enrolled in Medicaid that includes the use of a portion of the CANS-NY assessment tool (for NF and Hospital LOC) or the OPWDD ICF-IID tool that documents the applicant's needs, and determination that the applicant needs skilled nursing facility, ICF/IID or hospital level of care as required for participation in waiver. The HHCM uses the results of the eligibility evaluation and any additional assessments performed to develop a Plan of Care.

An eligibility re-evaluation is completed annually prior to every POC development by the HHCM using an algorithm based on a portion of the CANS-NY assessment tool or the OPWDD ICF-IID tool. The full CANS-NY assessment is performed for all HH members. The eligibility evaluation outlines the participant's needs. The HHCM utilizes this information in the development of the participant's plan of care.

The initial evaluation and re-evaluation takes into account the applicant's medical, social, habilitation and environmental barriers/needs, as well as the family's needs, strengths and abilities and is electronically signed by the HHCM Developmental Disabilities Regional Office (DDRO) staff member who conducts the evaluation.

Evaluation results are used to ascertain that the applicant needs skilled nursing facility, ICF-IID or hospital level of care as required for participation in waiver, and that the interventions are necessary for the child to be safely cared for at home or in the community.

During all steps of the eligibility evaluation/assessment process, the HHCM remains in contact with the waiver applicant's parents/legal guardians. The HHCM will assist with the Plan of Care Development including: scheduling the evaluation/assessment to accommodate the parent's schedule, serving as a conduit for the family to obtain information about the waiver, and informing the family of the choice of providers available to render the services.

Plan of Care Development
The HHCM reviews all documentation to determine waiver eligibility and maintains copies of the documentation required for eligibility as well as any additional assessment information and necessary documentation. The POC is developed in a person-centered discussion with the child and family, surrounding the strengths and needs of the child and their development of Plan of Care. The Plan of Care will specifically outline the types of services to be provided to the child and family by their chosen providers

The HHCM, with the assistance and input from the child's parent(s)/legal guardian(s), uses the information gathered from the evaluation/assessment to design a Plan of Care that will:
• Reflect that the setting in which the individual resides is chosen by the individual.
• Reflect the individual's strengths and preferences.
• Reflect clinical and support needs as identified through the eligibility evaluation/assessment of functional need.
• Include individually identified goals and desired outcomes.
• 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 are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.
• Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.
• Identify the individual and/or entity responsible for monitoring the plan.
• Include a method for the individual to request updates to the plan as needed.
• Be finalized and agreed to, with the informed consent of the individual in writing, and signed by family/participant

and providers responsible for its implementation.

Prior to any HCBS delivery, the HCBS provider must receive a referral from the participant's HH care manager. The HCBS provider will then evaluate the referral for appropriateness prior to delivery of any HCBS. After determining appropriateness, the HCBS provider can provide HCBS for the Initial Service Period beginning on the first date of billable service for the participant and is service specific. The Initial Service Period is the period of time after accepting an HCBS referral but prior to submitting an HCBS Authorization Request lasting up to 96 units/24 hours or 60 days (whichever comes first). The Initial Service Period is used to complete an intake assessment, to finalize service goals and objectives, and determine Frequency/Scope/Duration (F/S/D) for the service. For services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM which clearly indicates the participant's assessed needs and goals and must be necessary to assist a waiver participant to avoid institutionalization and function in the community. If the service is needed beyond the Initial Service Period, an HCBS approved Authorization is needed.

For Children served by HH: A Comprehensive Plan of Care (POC) is developed through the coordination of information from the CANS-NY assessment, the HCBS Eligibility Determination, the Health Home comprehensive assessment, and the inter-disciplinary team meeting which is a discussion with the child, their family, supports, and involved providers.

Health Home care managers develop a single Health Home comprehensive plan of care that includes all services a child needs (health, behavioral health, community and social supports, specialty services etc.) The Health Home comprehensive plan of care will be updated or developed to include HCBS for children that are eligible for HCBS and enrolled in Health Home – Health Homes will ensure the Health Home care plans meets care plan requirements for HCBS.

The POC must be signed by the responsible parent, guardian or legally authorized representative and the child/adolescent, if age appropriate. All involved providers, inclusive of the HCBS providers will be involved in the development of the POC and be given the opportunity to sign the POC whenever it is revised for any reason. However, at a minimum, the parent, guardian, legally authorized representative and/or child must sign the POC at least once, prior to submitting the completed POC. Updated and revised POC should also have the family and/or child/adolescent signatures, otherwise proper documentation would be needed in the care record how their input was part of the updated/revised POC and why a signature could not be obtained.

The HHCM will submit the child's POC to the MCO, if applicable.
The HHCM will follow up with the family at regular intervals to ensure linkage to services and that no changes are necessary. Contacting the child, parent, guardian, and legally authorized representative throughout the referral/intake process.

The State staff will forward a Medicaid application including a coversheet documenting that the child has been determined functionally eligible for aligned children's HCBS and has a POC developed if the child does not have Medicaid to the local district. The LDSS will ensure that financial eligibility is completed and enrollment in Medicaid is completed.

Plan of Care Update
The Plan of Care must be updated at a minimum annually, and reviewed every six months to clearly identify the current needs of the child. The plan must support that the participant's needs can be met through waiver services

Change in the participant's medical condition may require more frequent assessments of the child's needs and revision of all or part of his or her Plan of Care regarding the addition of necessary interventions or the removal of interventions for the child and family. The revised plan must be signed and dated by the HHCM/MCO Care Coordinator (MCOCC) and the participant's parents/legal guardian as well as any affected providers.

An eligibility evaluation is completed annually prior to every POC development. The HHCM/MCOCC utilizes information gathered in the eligibility evaluation and any additional assessments conducted in the development of the participant's plan of care.

The HHCM monitors and oversees the implementation of the POC through frequent communication with

parents/legal guardians. The MCO also reviews the State Plan services in the POC monitoring for managed care enrollees.

Case Records Maintenance
The original approved and signed Plan of Care is maintained in the applicant's case file by the HHCM and are made accessible to NYSDOH as needed. The MCO also maintains a copy of the approved Plan of Care for managed care enrollees.

Any subsequent approved revision of a participant's Plan of Care requires the participant's parent(s)/legal guardian's signature.

A copy of the participant's approved original Plan of Care and subsequent amendments are given to the participant and/or their parents/legal guardian.

The HHCM is responsible for the coordination of services identified on the POC. The HHCM works with the child's providers. This is accomplished by referrals with the physician, parents/legal guardian and other service providers.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☒ **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.**

☒ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☒ **A specific and individualized assessed need for the modification.**
- ☒ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☒ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☒ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☒ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☒ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☒ **Informed consent of the individual.**
- ☒ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Since waiver participants are under the age of twenty-one most live at home with their parents, the needs of the family as whole must be taken into account when developing the child's plan of care. The caregiver back-up plan, schedule, and availability of the informal caregivers (parents/legal guardian and possibly others) are reflected in the plan of care and affect the scope, duration, mix of HCBS services that may be required.

The plan of care is reviewed at least every six months (more often for HH members). Any changes needed in the plan of care to assure the safety of the participant may be brought to the attention of the HHCM, MCOCC or any caregiver at any time. The HHCM, MCOCC oversees the implementation of any change to the waiver participant's plan of care.

The participant is always part of the plan of care development. Participant's needs and preferences are discussed with the care manager when developing the plan of care. HHCM take into account the participant's preferences in developing strategies to mitigate potential and perceived risks which are set out and addressed in the plan of care.

The parents/legal guardians are given the HHCM contact information to assist the participant/parent/legal guardian in problem solving as needed.

MCOs must provide data to Health Homes and/or care management agencies to assist in outreach and engagement efforts, subject to any required agreements for sharing Medicaid Confidential Data in accordance with HIPAA and other state requirements regarding confidentiality. MCOs must include information in the Health Home Welcome Letter that encourages potentially eligible members to enroll in a Health Home by including a brief summary of the services and benefits provided by the Health Home. MCOs must continue periodic education to eligible members until member enrolls in a Health Home. This includes identifying opportunities for Health Homes to reengage in outreach (e.g., appearance at emergency room or inpatient hospitalization) and reassigning the member to a Health Home.

HHs and MCOs have hotlines and other emergency contact information that can be included in the plan. Each family opting out of HH will be given the information if a change in services or other issue arises. The HH or MCO can determine if emergency or crisis providers should be contacted or if other providers are needed to be called for back-up if health and welfare are jeopardized.

Individuals who are 18 years of age, parents, pregnant, and/or married, and who are otherwise capable of consenting, may exercise independent choice to disenroll from the HH during the HCBS enrollment process and each annual reevaluation or at anytime the individual/family contacts the Health Home.

HHs and MCOs have hotlines and other emergency contact information that can be included in the plan. The HH or MCO can determine if emergency or crisis providers should be contacted or if other providers are needed to be called for back-up if health and welfare are jeopardized.

For the child who is not yet Medicaid eligible and is newly in need of services, the local referral will be made to the State staff. With the appropriate consents from the child/family or legally authorized representative or guardian, the State staff will confirm the child is likely to be eligible for Medicaid, Health Home and/or HCBS; and:
- Perform HCBS Eligibility Determination (i.e., determine if the child meets target population, risk and functional HCBS eligibility criteria);
- If HCBS eligible, assist the family in completing the Medicaid application and submit the application to the local social service district;
- Refer the child and family to the Enrollment Broker for help with plan selection; and
- Once determined eligible for Medicaid, assist the child with Health Home selection and referral
- If the child enrolls in an MCO, share the HCBS POC with the MCO; and
- If the child remains in FFS, monitor access to care.

The HH is responsible for implementing the plan of care. The HH will coordinate State Plan services and the HCBS on the plan of care under 1945 of the Social Security Act.

The Health Home comprehensive assessment will identify service needs currently being addressed; service and resource needs requiring referral; gaps in care and barriers to service access; and the member's strengths, goals, and resources available to enhance care coordination efforts and empower individual choice and decision making.

The back-up plan may include provider agency contacts, school contacts, neighbors, religious and extended family available in the case that a worker is not available or there is an emergency.

An assessment of the participant's level of skills, and dignity of risk are identified during the service plan development process through person-centered planning. To evaluate “risk” and the individual’s responsibility and ability to calculate the risk, the participant, the HHCM take into consideration the benefits to the individual and the rights of the individual, ways to empower the person to improve their ability to make informed decisions through education and self-advocacy skills, possible resources and environmental adaptations that can allow the person to take the “risk,” but mitigate potential hazards.

The assessment will identify service needs currently being addressed; service and resource needs requiring referral; gaps in care and barriers to service access; and the member’s strengths, goals, and resources available to enhance care coordination efforts and empower individual choice and decision making. The care manager will assess risk factors that will include but not limited to HIV/AIDS; harm to self or others; persistent use of substances impacting wellness; food and/or housing instabilities.

The parents/legal guardians are given the HHCM contact information to assist the participant/parent/legal guardian in problem solving as needed.

In order to assure the health and safety of each waiver participant, the plan of care must account for the safety of the individual. Safety is essential to successful waiver participant and is a key consideration in plan of care development. All plans of care must demonstrate that the participant can be cared for in the home or community and is able to access necessary/wanted community services. The assessment and plan of care must address necessary home modifications, vehicle adaptations, and/or durable medical equipment that will benefit the waiver participant and allow caregivers to provide services for the child safely. In addition, the plan of care must identify supports needed to keep the participant safe from harm and actions to be taken when the health or welfare of the person is at risk. Safety is a significant issue discovered during the planning process that are individualized and specific to the participant; these include relevant medical and behavioral information.

Family of One children will be found functionally eligible by the State staff before they have Medicaid eligibility. The State staff will work with the local offices to determine financial eligibility.

On an on-going basis, the local offices will determine financial eligibility for all children.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The State will ensure a free choice of HHCM and providers through the State's freedom of choice form (form DOH-5276). In addition, all applicants and participants will be given a copy of the participant's rights and choice policy (Home and Community Based Services (HCBS) Children's Waiver).

The HHCM must offer all applicants/participant's the choice of available HCBS and providers. The HHCM is responsible for making sure that the waiver applicants/participants and their parents/legal guardians know of the participant's right to choose and change service providers, and that the HHCM will assist the participant in doing so.

The HHCM is also required to provide all applicants/participants with verbal and written notice of their rights under Medicaid.

The HHCM ensures that the participant understands his/her choice regarding services and providers. The HHCM maintains the list of available providers in the county (and in each MCO).

The HH provides the participant and or parents/ legal guardians with a list of approved HHCM and encourages the parents/ legal guardians interview potential CMs. The parents/legal guardians select the Care manager of their choice and signs and date the Choice of Care Management/Provider Selection form.

The State's standard is the HH.

Health Home are fully aligned comprehensive care management available to children.

Health Home. Regular FMAP rate. 1945 of the Social Security Act – HH SPA. Children eligible for and Opting into the Health Home:
- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Enrollee and Family Support
- Referral to Community and Social Supports
- Use of Health Information Technology to Link Services

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

Once functional eligibility has been determined within the UAS, NYSDOH also determines if there is capacity within the waiver (i.e., slot available) and communicates with the HHCM that enrollment may proceed and the POC is developed. NYSDOH will maintain communication with the HHCM/IE until resolution of any questions or concerns regarding the provision of necessary services to maintain the applicant at home or in the community.

MCOs, HH are routinely in contact with the families and providers regarding waiver applicants and services rendered to the waiver participant. MCOs, HHCMs monitor plans of care. If corrective actions are indicated, the MCOs or State staff will notify the provider in writing as to the actions necessary to remedy the situation. MCOs, NYSDOH or its designee will also evaluate the documentation from the plans of care against claim data acquired through the MCO claims payment or the FFS eMedNY to assure that services have been appropriately delivered in accordance with the approved plan of care. (For description of eMedNY, see section I-1).

The MCO, HHCM can request adjustments to the plan of care, either at time of application, at the six month review or any time during the review period when the MCO, HHCM determines that the proposed or implemented POC will not meet or is not meeting the needs of the applicant/waiver participant. If the necessary parties (providers, MCO, HH, and applicant/parent) cannot agree, the MCO Medical Director or NY Medical director or his/her designee will review case documentation and take action to resolve the situation. NYSDOH staff provide technical and professional assistance to the HHCM as needed.

The HH/MCO review all enrollment and annual reevaluation documentation. This includes Application form, Freedom of Choice form, Choice of Case Management/Provider Selection form, proof of age, proof of physical disability, proof of Medicaid eligibility, Level of Care, care management selection, MD orders (if any), and Plan of Care. Annually, the NYSDOH staff or its designee completes a statistically significant record reviews.

Services plans are subject to the approval of the Medicaid agency through the prior authorization process for FFS and Managed care. In addition, there is an in-depth review of a sample of service plans through routine provider reviews.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Safeguards

The 1915(c) will ensure choice of Case manager. The Children's Waiver, Health Home, case management comply with all federal COI requirements for the 1915c authority. HH will:
• Full disclosure to participants if a CMA also provides direct services,
• Participants will have freedom of choice of Health Home providers with the MCO controlling the participant choice process,
• Participants will be provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development,
• Children will have a clear and accessible grievance and appeal process as well as an alternative dispute resolution process;
• The provider agency that develops the person-centered service plan must administratively separate the plan development function from the direct service provider functions. Specifically, Health Homes that provide care management and direct services must ensure that the provider providing care management is not the same as the provider providing direct care services and that these individuals are under different supervisory structures.
• Health Home care managers are restricted from assessing a person for whom they have financial interest or other existing relationship that would present conflict of interest.
• DOH will conduct annual case record reviews to ensure that participants have been informed of their rights, have had an assessment of risk, full information about availability of provider choice, services, frequency and duration.

DOH will provide periodic evaluation of each Health Home to assure that Care Management Agencies that are also a direct service provider comply with the safeguards above.

In addition to reviewing and approving each plan of care, the HH/MCOCC continually monitors the plan of care. The MCOCC monitors any services on the plan of care for managed care enrollees. The HHCM maintains contact with the waiver applicants and their parents/legal guardians, waiver providers and NYSDOH staff. Identified issues are addressed directly by the HHCM or referred NYSDOH or the MCO for review and recommendations. The waiver participant/parents may contact the HHCM, MCOCC or NYSDOH staff at any time to discuss issues. Information about this process is relayed to all 1915(c) waiver applicant families at the time of application.

HHCM maintains open communication with all participants and their families. If services are not being provided, the participant/parent/legal guardian contacts the HHCM. The HHCM are in regular contact with the participant/parent/legal guardian to assess if services are being provided and back up plans are sufficient. If problems occur, the HHCM works with the MCO or NYSDOH staff and participant/parent/legal guardian to obtain additional services.

Any discrepancies between the plan of care and actual delivered services are identified through a range of methods including retrospective reviews of the plans of care, a retrospective paid claims review, provider surveillance, and/or information received by the HHCM, MCO, and/or NYSDOH staff. When problems are identified, further investigation is begun by an on-site visit to provider, or through formal referral to the appropriate agency for audit and review.

On a routine basis, NYSDOH staff monitors the program in conjunction with the Interagency Monitoring Team. Random review of cases are conducted by comparing paid claims to services authorized in the plan of care and parents of the participant are asked to certify that certain waiver services were provided and completed in accordance with an approved POC. Every waiver participant must have a recipient restriction/exception (R/E) code on his or her Medicaid enrollment file that identifies the child as a Children’s waiver participant. The eligibility worker is responsible for putting the Children’s R/E code and effective date on the participant’s WMS file.

Waiver service delivery is also monitored through participant feedback, such as the CAHPS survey of managed care members, to gather input about their experiences in the managed care program.

When NYSDOH or its designee or the MCO conducts a random review of all Children’s cases, the HH is notified in writing of any deficiencies and a corrective plan is noted. Depending upon the findings, corrective action may be required immediately or within the next re- assessment period, as appropriate by NYSDOH. If issues are noted by the HHCM, MCOCC, NYSDOH or another oversight agency, NYSDOH staff in conjunction with the HH will conduct a case review including POCs, paid claims, and other documentation from waiver participants/parents. Written reports and, if necessary, correction plans may be required. If services continue to be out of compliance with the participant’s POC or

inconsistent with State and federal regulations, NYSDOH may take steps to terminate the provider's enrollment status.

NYSDOH staff, the MCO, and HH monitors whether participants are afforded choice of providers, whether services are meeting their needs, whether back up plans are effective and participants' health and welfare is being maintained through a variety of mechanisms. These include: monitoring of complaint calls, HH, MCO, reports, monthly conference calls, care manager calls, and care manager reports. If trends are noted or problems arise, NYSDOH or MCO holds a conference call with the HHCM and participant/family/legal guardian if needed to address the situation or resolve the issue.

In addition to reviewing and approving each plan of care, the HH continually monitors the plan of care. The HHCM maintains contact with the waiver applicants and their parents/legal guardians, waiver providers and NYSDOH staff. The HHCM maintains contact as required by the schedule of contacts as required by the acuity of the child according to the health home contact schedule.

The waiver participant/parents may contact the HHCM or NYSDOH staff at any time to discuss issues. Information about this process is relayed to all 1915(c) waiver applicant families at the time of application. HHCM maintain open communication with all participants and their families.

Specific monitoring methods are addressed below:
Identified issues are addressed directly by the HHCM or IE or referred to NYSDOH for review and recommendations.

- Services furnished in accordance with the service plan;
If services are not being provided in accordance with the service plan, the participant/parent/legal guardian contacts the HHCM, or MCO (if applicable). The HHCM are in regular contact with the participant/parent/legal guardian to assess if services are being provided and back up plans are sufficient.
- Participant access to waiver services identified in service plan;
Any discrepancies between the plan of care and actual delivered services are identified through a range of methods including retrospective reviews of the plans of care, a retrospective paid claims review, provider surveillance, and/or information received by the HHCM, MCO, and/or NYSDOH staff.

On a quarterly basis, NYSDOH staff monitors the program in conjunction with the Interagency Monitoring Team. Random review of cases are conducted by comparing paid claims to services authorized in the plan of care and parents of the participant are asked to certify that certain waiver services were provided and completed in accordance with an approved POC.

The New York State Department of Health (NYSDOH) sponsors a member experience survey every other year for adults enrolled in Medicaid managed care plans. The Department uses the results from this biannual survey to determine variation in member satisfaction among the plans and issues a statewide Continuous Quality Improvement Report to improve quality and track issues identified in the survey.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. CAHPS, a program of the U.S. Agency for Healthcare Research and Quality, provides nationally used surveys that cover topics that are important to consumers, such as communication skills of providers and ease of access to healthcare services, health care providers and health plans.

DataStat, Inc. conducts the survey on behalf of the NYSDOH using the CAHPS 5.0H Adult Medicaid survey. There is a statewide summary report for Medicaid Managed Care plans, and there are 15 plan specific reports. There is also a statewide summary report for HIV Special Needs Plans and 3 plan specific reports.

- Participants exercise free choice of provider;
NYSDOH staff, the MCO, and HH monitors whether participants are afforded choice of providers, whether services are meeting their needs, whether back up plans are effective and participants' health and welfare is being maintained through a variety of mechanisms. These include: monitoring of complaints, MCO, HH, monthly conference calls with contractors, care manager calls, and care manager reports. All reports are monitored. The CM conducts the health and welfare calls as required by the type of Care Management (HH-according to acuity). If there are issues found, the NYSDOH or MCO holds the conference call as noted. If trends are noted or problems arise, NYSDOH holds a conference call with the HHCM and participant/family/legal guardian if needed to address the situation or resolve the issue. The annual case

record review performed by DOH will also ensure that free choice forms were completed as required.

- Services meet participants' needs;
The HHCM continually monitors the plan of care to determine if the services meet participants' needs. The participant/parent/legal guardian may also contact the HHCM if there is an issue. The HHCM maintains contact with the waiver applicants and their parents/legal guardians, waiver providers and NYSDOH staff, according to the acuity of the child and the HH contact schedule.

- Effectiveness of back-up plans;
The participant/parent/legal guardian contacts the HHCM, if there is an issue. The HHCM is in regular contact with the participant/parent/legal guardian to assess if back up plans are sufficient.

-Participant health and welfare;
All MCOs must provide SDOH on a quarterly basis, in a manner and format determined by SODH, a report of critical incidents identified and/or investigated by the Contractor involving Enrollees in receipt of long term services and supports.

The New York State Department of Health (the Department) is responsible for the oversight of Health Homes (HH), a care management service model which ensures all of the professionals involved in a member´s care communicate with one another so that the member's medical, behavioral health (mental health and/or substance use disorders), and social service needs are addressed in a comprehensive manner. A reportable incident is an event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of the member.

Health Home policies and procedures must mandate that the CM inform the HH of a reportable incident within 24 hours of notification or discovery.

The HH must inform the Department within 24 hours of notification from the CM.

The Department will review the incident reported by the HH and make recommendations, if necessary, to ensure that the Health Home's reportable incident policy is appropriate and in compliance with established HH Standards. The Department will require HHs to submit, on a quarterly basis, the total number of reports in each of the categories noted on the Health Home Reportable Incident Form, due by the 10th business day after the end of the quarter: • January – March, due April; • April – June, due July; • July – September, due October; and • October – December, due January.

- Participant access to non-waiver services in service plan, including health services;
The participant/parent/legal guardian contacts the HHCM or MCO (if applicable) if access to non-waiver services in the service plan are not being delivered, including health services. The HHCM is in regular contact with the participant/parent/legal guardian to assess if non-waiver services are being provided.
- Methods for prompt follow-up and remediation of identified problems.
If problems occur, the HHCM works with the MCO or NYSDOH staff and participant/parent/legal guardian to obtain additional services. When problems are identified, further investigation is begun by an on-site visit to provider, or through formal referral to the appropriate agency for audit and review.

When NYSDOH or its designee or the MCO conducts a random review of all Children's cases, the HH is notified in writing of any deficiencies and a corrective plan is noted. Depending upon the findings, corrective action may be required immediately or within the next re- assessment period, as appropriate by NYSDOH. If issues are noted by the HHCM, NYSDOH or another oversight agency, NYSDOH staff in conjunction with the HH, will conduct a case review including POCs, paid claims, and other documentation from waiver participants/parents. Written reports and, if necessary, correction plans may be required. If services continue to be out of compliance with the participant's POC or inconsistent with State and federal regulations, NYSDOH may take steps to terminate the provider's enrollment status.

NYSDOH OHIP aggregates of the annual random review of all Children's cases, claims, grievances, and incident reports from the MCO, HHs. If the NYSDOH identifies an issue, the HH/MCO is notified in writing of any deficiencies and a corrective plan is noted. Depending upon the findings, corrective action may be required immediately or within the next re- assessment period, as appropriate by NYSDOH. If issues are noted by the HHCM, NYSDOH or another oversight agency with licensing authority, NYSDOH staff in conjunction with the HH/MCO, will conduct a case review including

POCs, paid claims, and other documentation from waiver participants/parents. Written reports and, if necessary, correction plans may be required. If services continue to be out of compliance with the participant's POC or inconsistent with State and federal regulations, NYSDOH may take steps to terminate the provider's enrollment status.

b. Monitoring Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participantsï?½ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of POCs reviewed that address all participants assessed needs including risk factors and personal goals, either by the provision of waiver services or through other means (N Number of POCs that address all participants assessed needs including risk factors and personal goals, either by the provision of waiver services or through other means/D Total number of POCs reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Person-centered plan record reviews or through Utilization Review Unit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = CI=95% +/- 5% margin of error
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participant POCs reviewed that have adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s) (N Number of participant POCs reviewed that have adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s) / D Total number of participant POCs reviewed)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = CI=95% +/- 5% margin of error
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants whose POC was updated/revised at least annually (within 365 days of the last POC evaluation) (N Number of participants whose POC was updated/revised within 365 days of the last POC evaluation / D Total number of participants whose POC was due to be updated/revised that were reviewed)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = CI=95% +/- 5% margin of error
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Number and percent of participants whose POC was updated as warranted by (a significant life change or) changes in the participant's needs (N Number of participants whose POC was updated as warranted by (a significant life change or) changes in the participant's needs / D Total number of participants who had (a significant life change or) changes in the participant's needs that were reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = CI=95% +/- 5% margin of error
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants reviewed who received services in accordance with the service plan including the type, scope, amount, duration and frequency specified in the service plan(N Number of participants reviewed who received services in accordance with the service plan including the type, scope, amount, duration and frequency specified in the service plan/D Total participants reviewed)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
FFS Claim & MC Encounter Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Less than 100% Review; Representative Sample CI=95 +/- 5% margin of error
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participant records reviewed with a completed signed freedom of choice form that specifies choice was offered between/among waiver services and providers(N Number of participant records reviewed with a completed signed freedom of choice form that specifies choice was offered between/among waiver services and providers/D Total number of participant records reviewed)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = CI=95% +/- 5% margin of error
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

NYSDOH, IMT, and MCOs monitor waiver and HH providers that operate in New York State by conducting standard inspections at least every three years that include State licensure, federal initial certification, and recertification surveys to ensure the agencies meets all governing Medicaid federal and State guidelines. All significant issues/deficiencies identified during such survey, or by complaint or any other means, must be shared with NYSDOH waiver management staff. Uncorrected deficiencies findings may jeopardize waiver provider status.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The remediation process is initiated when the MCO or NYSDOH staff or Interagency Monitoring Team identifies a lack in the quality of provided services or any other issue related to administration of waiver services including an issue with a HHCM. During the annual case reviews, NYSDOH or its designee performs quality reviews of POC development, review and updates to ensure that the proper forms and processes are used, the POC revisions are made timely and when needed, the needs and goals of the child/family are addressed, and the federally required elements of a POC are incorporated. In instances when it is discovered that this has not occurred the team recommends that the HHCM take steps to address the deficiency. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

In such situations, the standard procedure is for NYSDOH staff, Interagency Monitoring Team, and MCO to discuss the situation and for NYSDOH to issue a statement of deficiency(ies). The HH must provide a plan of correction and address any issues at the child/family level. NYSDOH staff, the IMT and MCO may collaboratively work with the HH to develop a plan of correction, if necessary. Implementation of and compliance with the plan of correction are monitored by NYSDOH and MCO.

If the plan of correction requires a change in the participant’s service, NYSDOH staff and the MCO will work cooperatively to address the service deficiency and when necessary, transition the child to another waiver provider. The HHCM will communicate any changes needed to the family and help the family find alternative providers. To ensure continuity of service during the transition period, the original provider will be required to transfer the participant case records and other pertinent documents to the new provider until transition is complete.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide waiver services. The provider may be referred to the licensure or certification agency staff, as needed. Accordingly, NYSDOH staff, or its designee the IMT, will issue a letter to the provider terminating the provider’s waiver designation provider status.

After 3/1/2024, the FMS responsible for providing FMS services will identify unsatisfactory vehicle modification, home modification, adaptive and assistive technology, and transitional services (effective 1/1/2026) contractors. The FMS will disqualify unsatisfactory contractors and will find alternate contractors when necessary.

Unsatisfactory accessibility modification and adaptive and assistive technology contractors will be notified of their disqualification from further service by the administering MCO, FMS, and DDRO and LDSS (through the transition). The HHCM will help the family find alternate contractors.

Documentation of remediation activities is accomplished by the following measures: correspondence among NYSDOH waiver management staff, MCO staff, the CM, participants’ and their parents/legal guardians, and/or service providers;

amended plans of care; case reviews and reports of follow-up meetings with participants and their families documented by MCO and HH; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file. Circumstances involving remediation are maintained, as appropriate, by NYSDOH and/or the MCO

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take

advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Self-Direction under the Children's waiver facilitates the purchase of Adaptive and Assistive Technology (AAT), Environmental Modifications (E-Mods), Vehicle Modifications (V-Mods), and Transitional Services (TS). Those services are administered by a Financial Management Services (FMS) agency who is the provider of record for billing purposes. The FMS assists the family or participant to: (a) manage the disbursement of funds; (b) facilitate solicitation of and payment for AAT, E-Mods, V-Mods, and TS by assisting the participant's selection of vendors, verifying qualifications, payment of invoices, and reporting payments to appropriate tax authorities as required; and (c) performing fiscal accounting and making expenditure reports to the participant or family and state authorities. No other services are self-directed.

When a child or youth is found to require one of these three services (AAT, E-Mods, TS, and V-Mods) during the plan of care meeting, the HHCM will assists the person in accessing the FMS, explains self-direction with the FMS for service delivery and choice of vendors/contractors/companies. HHCM provide information on the supports and services available through the waiver so participants can make informed choices on the service options that best meet their needs and that will enable them to live as independently as possible in the community. The Care Manager informs them about how to utilize the FMS for AAT, E-Mods, TS, and V-Mods.

Agency Supported Self Direction with Budget Authority: For individuals who self-direct with budget authority, the Financial Management Services agency functions as the entity that procures the AAT, E-Mods, TS, and V-Mods for the individual and operates as an Organized Health Care Delivery System (OHCDS). AAT, E-Mods, TS, and V-Mods are paid via a Financial Management Services agency for HCBS Waiver enrollees who qualify for these services, only, even though other HCBS Waiver services are not self-directed.

To facilitate participant direction, self-direction participants are assisted by the FMS agencies in procuring AAT, E-Mods, TS, and V-Mods. AAT, E-Mods, TS, and V-Mods are approved up to the soft limits, based upon requirements in the waiver with expenditures above that amount subject to prior approval.

The FMS agency is a Health Home for Children agency authorized by DOH to assist children/youth and their families purchase AAT, E-Mods, TS, and V-Mods approved by the State. The FMS will be operated under an approved initial/concurrent 1915(b)(4) waiver (NY.0015).

The FMS agency makes purchases, manages, and directs the disbursement of funds from the vendors/ contractors/companies selected by the member and performs any necessary fiscal accounting, and expenditure reporting for the person, representatives, and state authorities.

Through the tools described above, DOH is committed to continuing to promote participant direction in the waiver-funded services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ◉ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ○ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Waiver-enrolled children who may also be in a foster care placement, with a foster parent or kinship care home.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Self-direction is only for AAT, E-Mods, TS and V-Mods. If families/children do not want to self-direct, the FMS will manage the process of purchasing of AAT, E-Mods, TS and V-Mods directly with the Care Manager, subject to participant choice.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Every individual who seeks AAT, E-Mods, TS, and V-Mods services according to their Plan of Care and meeting Waiver requirements from DOH under the Children's waiver is informed of the opportunity to self -direct their services by their care manager and the FMS. All individuals who receive services through the Children's Waiver must have access to care management services (See Appendix D for more information on care management). HHCM ensure that participants have the information necessary to make informed choices regarding the supports available to them, including self-direction services, and helps ensure the participant's personal choices are incorporated for these specific Waiver services.

The FMS will continue the education that begins with the HHCM about AAT, E-Mods, TS, and V-Mods participant-directed service options.

Multiple written resources are available to assist individuals to understand AAT, E-Mods, TS, and V-Mods. The HHCM assists in connecting participants to the FMS for further information. The FMS offers information to individuals and their families that provide detailed information on the benefits of AAT, E-Mods, TS, and V-Mods, the responsibilities, and liabilities, and how to obtain these services. In addition, the FMS will also have one-on-one assistance for each individual. The FMS process flow is to have a conference call with the HHCM and the member/family to review the AAT, E-Mods, TS, and V-Mods being requested. This will be an opportunity for the FMS to answer questions and clearly outline the process and expectation to the member/family. This is also an opportunity for the member/family to explain their choice for the AAT, E-Mods, TS, and V-Mods. Additionally, the FMS will be available for questions and further communication with the HHCM and the member/family, as needed.

It is through the FMS that individuals are able to obtain AAT, E-Mods, TS, and V-Mods.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A) Waiver services are participant-directed when the individual receiving the services: is an adult 18 years old up to 21 years old who is capable and willing to make informed choices and manage the self-directed options.
B) Waiver services are directed by a designee of the participant when the individual receiving services is:
i. A capable adult age 18 years old up to 21 years old who has designated another adult who is capable and willing to make informed choices and manage the waiver services for the participant; or
ii. A capable adult who has designated another adult who is capable and willing to make informed choices and manage the waiver services for the participant, and the participant has given the other adult a power of attorney to make informed choices and manage the waiver services for the participant.
C) Waiver Services are directed by the guardian of the individual receiving services. The guardian's decisions and actions shall afford the individual the greatest amount of independence and self -determination with respect to waiver services and service planning, in light of the individual's functional limitations, and personal wishes, preferences and desires. A guardian will act in this capacity when the individual receiving services:
i. is an adult age 18 years old up to 21 years old whom a court of competent jurisdiction has determined is incapable of making informed choices and for whom such court has appointed a guardian who is a natural person to make informed choices regarding waiver services; or
ii. is a minor whose parents(s) or guardian is an adult capable of making informed choices regarding waiver services; or
iii. is a minor
(a) whose parent(s) or guardian is capable; but
(b) has designated another adult to make informed choices regarding waiver services; and
(c) the other adult is capable and willing to make informed choices regarding waiver services.
Some of the responsibilities of the legal guardian and/or the identified adult, on behalf of the participant include:
- Ensuring that the AAT, E-Mods, TS, and V-Mods meet the needs of the child/youth
During the planning stages for self-direction, a Care Manager identifies safeguards that need to be in place to ensure that the best interests of the individual are met, if applicable.
In the Children's Waiver, it is assumed that every child/youth and his/her family has the ability and the right to direct his/her AAT, E-Mods, TS, and V-Mods. DOH authorizes AAT, E-Mods, TS, and V-Mods services in conjunction with the FMS.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Vehicle Modifications	☐	☒
Adaptive and Assistive Technology	☐	☒
Financial Management Services	☐	☒
Transitional Services	☐	☒
Environmental Modifications	☐	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Health Homes Serving Children that are HCBS waiver authorized as an FMS agency, as outlined in the 1915(b)(4), may furnish FMS. Approved agencies have Medicaid provider agreements and must adhere to all applicable tax law related to purchases. For individuals who self-direct with budget authority, Financial Management Services providers function as the entity that procures the AAT, E-Mods, TS, and V-Mods for the individual and function as an Organized Health Care Delivery System (OHCDS).
When a person makes an application for AAT, E-Mods, TS, and V-Mods the HHCM provides information about approved FMS. This waiver is concurrent with a 1915(b)(4) selective services waiver for selective contracting of FMS providers.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS are compensated through a flat fee for service fee schedule.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☐ **Assist participant in verifying support worker citizenship status**

☐ **Collect and process timesheets of support workers**

☐ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

Facilitate solicitation of and payment for AAT, E-Mods, V-Mods by assisting the participant's selection of vendors and contractors

Supports furnished when the participant exercises budget authority:

☐ **Maintain a separate account for each participant's participant-directed budget**

☐ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☐ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

FMS is closely monitored by DOH as the FMS agency performs fiscal accounting and provides regular expenditure reports to DOH, and providing DOH with reports of expenditures and the detailed status of the AAT, E-Mods, TS, and V-Mods purchases when requested. DOH will monitor bi-annual and annual expenditures and will conduct case reviews.

Once the plan of care has the AAT, E-Mods, TS, and V-Mods noted and the application for the service submitted, the participant and family will have a choice of service providers. Additionally, after the determined vendor is selected and a scope of work is developed, the participant and their family will review the scope and cost for the project and sign-off. The participant, their family and the HHCM has an opportunity to review the service delivery of AAT, E-Mods, TS, and V-Mods during specific times of project implementation. The participant, family and the HHCM must review and sign understanding, choice was given, and completion of work according to the approved scope. Additionally, the participant, family and HHCM can request a meeting/conference to discuss the service delivery and or file a complaint/grievance at any time. Family will sign final paperwork which will include costs of the project.

Services are billed to eMedNY using separately identified rate codes. AAT, E-Mods, TS, and V-Mods are approved up to the soft limits in the waiver with expenditures above that amount subject to prior approval. FMS bill only for those AAT, E-Mods, TS, and V-Mods that are in the POC and do not bill Medicaid until there has been expenditures for those approved AAT, E-Mods, TS, and V-Mods. Cost and project reporting to DOH is required on a bi-annual and annual timeframe.

OMIG has an audit plan which ensures coverage of all waiver services including any services that are self-directed (as described in Appendix I-1).

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Care management is the vehicle that drives all HCBS including self-directed service options. Every individual who receives services through the HCBS waiver must have access to care management. Care management services are designed to assist individuals to gain access to needed waiver services, state plan, and other appropriate supports regardless of the funding source. Care Managers provide information on the supports and services available through the Children's waiver so participants can make informed choices on the service options that best meet their needs and that will enable them to live as independently as possible in the community.

A primary responsibility of the HHCM is to maintain and update the POC and ensure that approved supports and services are delivered, regardless of participant-direction or traditional provider-managed services, and to help determine whether the participant is satisfied with their participant-directed services. Through these processes, the HHCM provides information and assistance in support of the services the person receives. The HHCM must notify the DOH Children's waiver team of issues involving the participant's dissatisfaction as well as issues that may compromise health and safety and obstacles that prevent the participant's plan from being fully implemented.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3

(check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Vehicle Modifications	☐
Supported Employment	☐
Adaptive and Assistive Technology	☐
Financial Management Services	☒
Transitional Care Coordination	☐
Transitional Services	☐
Palliative care – Pain and Symptom Management	☐
Prevocational Services	☐
Palliative care – Massage Therapy	☐
Community Habilitation	☐
Palliative care - Expressive Therapy	☐
Caregiver/Family Advocacy and Support Services	☐
Non-Medical Transportation	☐
Respite	☐
Day Habilitation	☐
Environmental Modifications	☐
Palliative care – Counseling and Support Service	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

The first level of independent advocacy available in participant-directed services stems from the participant's guardians or representatives whose members are natural supports to the participant and assist in ensuring that approved supports and services are delivered.

Individuals utilizing participant-directed services continue to receive Care Management from a HHCM. A primary responsibility of the FMS is to ensure that approved supports and services are delivered, regardless of participant-direction, and to help determine whether the participant is satisfied with their AAT, E-Mods, TS, and V-Mods. The HHCM acts as a link between HCBS waiver staff at DOH and the child/youth and family. The FMS, HHCM must notify the DOH waiver team of issues involving the participant's dissatisfaction as well as issues compromising health & safety and obstacles preventing the participant's plan from being fully implemented.

If an individual is not pleased with the performance of the FMS, he/she can contact the HHCM for assistance in resolving any issues. Additionally, the participant, family and HHCM can request a meeting/conference to discuss the service delivery and or file a complaint/grievance at any time. If necessary, the DOH waiver staff is available to assist, as well or the person can contact DOH to register a complaint with Central Office.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Individuals may choose at any time to terminate their AAT, E-Mods, TS, and V-Mods. This process is facilitated through the HHCM. A period of at least 30 days is requested to allow the FMS to notify any vendors. The HHCM will work with the participant to ensure continuity of service provision and health and safety.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

This situation is not anticipated because only purchased services are self-directed. The FMS is responsible for the purchase of AAT, E-Mods, TS, and V-Mods up to the soft limits and following Waiver requirements with expenditures above soft limits subject to prior approval from DOH.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		0
Year 2		25
Year 3		313
Year 4		334
Year 5		381

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver 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. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☐ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☐ **Hire staff common law employer**
☐ **Verify staff qualifications**
☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☐ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☐ **Schedule staff**

☐ **Orient and instruct staff in duties**

☐ **Supervise staff**

☐ **Evaluate staff performance**

☐ **Verify time worked by staff and approve time sheets**

☐ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☐ **Reallocate funds among services included in the budget**

☐ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☐ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☒ **Other**

Specify:

Select contracted vendors/ contractors/companies of AAT, E-Mods, TS, and V-Mods.
The participant and family can identify vendors/contractors/companies of AAT, E-Mods, TS, and V-Mods and refer for provider enrollment with the FMS.
Work with vendors/contractors/companies of AAT, E-Mods, TS, and V-Mods to ensure that the child/youth and family needs are met subject to DOH approval.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Requests for AAT, E-Mods, TS, and V-Mods are limited to the maximum amount medically necessary for meeting the needs of the child/youth and family as outlined in the approved waiver (note: soft limits are outlined and expenditures above that amount are subject to prior approval by DOH). Participants may not request projects for more than is medically necessary and the FMS will not be reimbursed for services and supports that are above the DOH approved amounts.

Children living at home may self-direct (or family-direct) their services, but the maximum amounts reflect their status as a minor, dependent child and a recipient of services through the school. This information is available to HHCM assisting individuals who choose participant-direction via the Regional Office Self-Direction Liaison and is available to the public upon request.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Participants who choose to direct their services can get information regarding the requesting AAT, E-Mods, TS, and V-Mods at the beginning of the planning process with their care manager during the development of their plan of care. Once an evaluator has developed the scope of service or a search of available technology has been completed based upon the participant's need that meets medical necessity and the participant's choice, the participants are given a medically necessary target value. These are only meant to be, as stated, a targeted value. A person's budget can be less than or equal to the target value, but cannot exceed the target value. Through the person-centered planning process, the person requests the AAT, E-Mods, TS, and V-Mods which the purchase is then facilitated by the FMS. First, an evaluator has developed the scope of service, or searches available technology that is medically necessary and a budget is established based upon the cost of the Adaptive and Assisted Technology or bids for Environmental/Vehicle Modifications. Final authorized expenditures can be less than or equal to the budget, but cannot exceed the budget.

Participants can also request to modify the AAT, E-Mods, TS, and V-Mods during the implementation phase to achieve evolving personal goals and valued outcomes, and to prevent institutionalization. Participants are assisted through these change processes by the HHCM and/or FMS to ensure Waiver requirements are met. Modifications must be approved by the FMS and NYS DOH.

A participant has a right to a Fair Hearing on a denial, termination or reduction of AAT, E-Mods, TS, and V-Mods as long as the requested project or purchase does not exceed the target value. A request to exceed the medically necessary target amount or for a project/purchase that is not medically necessary is not a fair hearable issue.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The HHCM or FMS can assist with the facilitation of the change in POC and the FMS will have a HCBS provider plan based upon change in need that meets medically necessity requirements. An updated scope and budget would be developed if modifications are needed, such as an increase in the price of materials due to inflation.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

There are a number of safeguards and other resources designed to prevent the premature depletion of the participant-directed resources for AAT, E-Mods, TS, and V-Mods as well as to address potential problems related to service delivery.

The main function of HHCM and the FMS in AAT, E-Mods, TS, and V-Mods is to assist the participant to purchase AAT, E-Mods, TS, and V-Mods. The FMS reviews the project expenditures to ensure it is within budget and scope, any changes or impact to the participant will be reviewed and discussed to ensure that expenses are appropriate. The HHCM act as a primary safeguard as well. Other areas of support include:

--continual identification of revised or emerging valued outcomes and the AAT, E-Mods, TS, and V-Mods needed to address them;

--review of budget expenditure reports to ensure that available resources remain adequate to meet approved AAT, E-Mods, TS, and V-Mods;

--assistance in ensuring that risk, responsibilities, and consequences are understood and adhered to and that safeguards are revised, if needed, to adequately address needs, and;

--helping to ensure that health and safety concerns are immediately identified and addressed.

A core function of FMS Services is to develop and implement an accounting and information system to track and report AAT, E-Mods, TS, and V-Mods expenses. The FMS makes purchases based on current, approved AAT, E-Mods, TS, and V-Mods requests which outlines the costs the purchase/project will incur and how these costs will be paid by the FMS. The FMS must ensure that necessary payments are made.

The FMS must develop a mechanism to identify when expenses in excess of expected spending will occur and report to the participant (or authorized designee where appropriate) and to the DOH waiver office. DOH must approve any expenses in excess of soft limits in the waiver. The FMS must also generate detailed expenditure reports to individuals and DOH waiver team, in these circumstances. These reports must be customized, as appropriate to their intended audience, to ensure that participants and DOH can understand them. The FMS will work with the participant and DOH to determine the need to revise the AAT, E-Mods, TS, and V-Mods request.

An FMS checklist, which highlights the general responsibilities of the FMS, is shared with all individuals using FMS for AAT, E-Mods, TS, and V-Mods. On-going training is also provided to all parties on their roles and responsibilities.

All FMS purchases will be reported to DOH. In order to prevent a conflict of interest, the DOH waiver team reviews AAT, E-Mods, TS, and V-Mods above annual soft limits and confirms the services/purchases are utilized. DOH or its Designee will also perform annual case file reviews on a sample of cases.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR ?431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Children's waiver applicant/participant is informed of his/her fair hearing rights at the time of application for Medicaid benefits by the LDSS/HRA. The Medicaid application and MCO member materials includes information to the applicant regarding their general Medicaid rights. The participant is informed that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing as part of the program information given to the member.

Additionally, the HHCM ensures that the waiver applicant understands: his/her rights, access to case conferences and Fair Hearings as they proceed through the waiver enrollment process, and throughout the duration of the participant's waiver enrollment.

Eligibility
Once the application for the Children's waiver program has been reviewed an automated acceptance/denial is generated for the HHCM. The Health Home issues a Notice of Determination/Decision (NOD) to the applicant based on that automated acceptance/denial. A Notice of Determination/Decision (NOD) is written documentation from the Health Home that notifies the applicant/participant of an action taken by the waiver program, including an explanation of the reasons for the action. Notices of Determination/Decision (NOD) are issued when an applicant has been approved or denied acceptance into the waiver, or if the participant is being discontinued. The Health Home must give the waiver applicant/participant adequate and timely notice when approving or denying waiver applications and/or when terminating a waiver participant's benefits. The Health Home sends a written NOD to the participant. Participants are informed of their fair hearing rights in the NOD that is mailed to the participant and have 60 days to request a hearing.

Individuals in receipt of a NOD for eligibility issues related to the Children's waiver are eligible for an Informal Conference and/or a Fair Hearing. Children's applicants and participants have Fair Hearing rights under 18 NYCRR §358-3.1(b)(6). The regulation for the opportunity for a fair hearing is found in: 18 NYCRR 358-3.1 and for managed care, at 18 NYCRR 360-10.8.

Plan of Care Services
In addition to the required notices for eligibility, the HHCM will exercise due diligence in advising participants about changes in the participant's Plan of Care, providers, available services and method of service delivery. A NOD is issued by the MCO or NYSDOH if a request for services are denied or limited or if existing services are terminated or limited (reduction) by the MCO or the NYSDOH. Participants of the waiver can request a State Fair Hearing at any time if they feel that the services which they are receiving are not adequate. Fair Hearing requirements require the entity providing the decision (e.g., MCO, NYSDOH, or Health Home) to provide applicants/participants with timely and adequate notice of Fair Hearing rights when benefits under the waiver are denied, discontinued, or reduced.

Timely and adequate means that the effective date of the adverse action is 10 days after the date the notice was issued. If the individual is enrolled in managed care, the MCO will issue timely and adequate notice when terminating or limiting a waiver participant's benefits. This enables the individual time to exercise the MCO appeal (if enrolled) and State fair hearing rights. The Notice of Determination/Decision form includes instruction as to how to exercise the right to a managed care appeal, or if in FFS, an Informal Conference, as applicable, and State fair hearing.

A member enrolled in managed care must exhaust a plan appeal only where a plan made a decision to deny services. If the member is disputing the level of authorized care, the member can request more services. If the plan denies the increase request, then there is an MCO decision to appeal. If there was never a plan decision (i.e., an eligibility decision or prior to a utilization review decision by the MCO), the member can file State Fair Hearing at any time if they think their Medicaid benefits have been limited or delayed.

The NOD is sent if there is a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or for an enrollee in receipt of HCBS services and support, if there is a determination to partially approve, terminate, suspend, or reduce level or quantity of long term services and supports for a subsequent authorization period of such services. A participant/legal guardian does not generally have a right to Aid Continuing for concurrent review determinations for extended services beyond the original authorization period unless the above circumstances exist. The NYDOH or MCO must still provide Aid Continuing if so directed by the Office of Administrative Hearings. When the appeal or fair hearing is adverse to the enrollee, enrollees may be held liable for the cost of services they received during the appeal or fair hearing review as provided by 42 CFR 438.420(d). NYDOH or MCOs will not attempt to recoup such costs after an upheld Plan appeal until after the enrollee fails to request a fair hearing within 10 days of the Final Adverse Determination, or, for enrollees requesting a fair hearing, until after the adverse fair hearing decision. Participants are informed of their fair hearing rights in the NOD that is mailed to the participant. Participants are informed of their right to continuation of benefits in the NOD that is mailed to the participant.

Once a NOD is issued for a termination or reduction of existing services, the HHCM is responsible to ensure the participant/legal

guardian understands their his/her right to file an appeal (for managed care members) or informal conference/fair hearing (for FFS participants) within ten days of the decision in order to be eligible for Aid Continuing. “Aid Continuing” means a participant has a right to the continuation of their already existing benefits until the appeal or fair hearing process is completed and a decision is rendered. If the request for appeal/fair hearing is not completed in the ten days window, the participant/legal guardians have 60 days from the notice date to request an appeal/fair hearing, but will not receive Aid Continuing. Managed care enrollees have 60 days to request a State fair hearing from the MCO appeal determination.

HHCM/NYSDOH or its designee may assist the participant/legal guardian in filing appeals and Fair Hearing requests to prepare for and to provide any needed documentation on record to support the participant’s case to the Administrative Law Judge at the hearing. However, the HHCM may not present evidence and/or a position at a fair hearing for the participant/legal guardian. The Health Home and MCO serves as the representing agent for NYSDOH at fair hearings.

The HHCM is also responsible for explaining to the participant that when an appeal/fair hearing and Aid to Continue is requested, services remain in place until appeal/fair hearing disposition. The participant’s MCO will provide information relating to appeals per 42 CFR 438 subpart F and the State’s contract with the MCO. A copy of the fair hearing request and scheduling information is sent from Office of Temporary Disability Assistance (OTDA), which is responsible for managing and overseeing Fair Hearings for Medicaid issues, to the Health Home/MCO, as applicable, and the participant.

To assure statewide uniformity, NYSDOH has advised the Health Home/ MCO about appeals and fair hearing procedures and related official forms in the Health Home/MCO contracts.

A copy of the NOD and Fair Hearing information is kept in the participant’s records maintained by Health Home/MCO and the Care Manager.

MCOs/HH must separately track and report complaints, grievances, appeals, and denials related to the children’s populations and services covered including Children’s HCBS services under this waiver.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

New York State Public Health Law Article 49 provides a right to external appeal by an independent reviewer at no cost to Medicaid recipients, when an MCO denies a service request due to lack of medical necessity or as experimental/investigational. The New York State Department of Financial Services operates the external appeal process. Upon receipt of an initial adverse determination, if a delay will cause harm to the enrollee, the enrollee may request an expedited external appeal at the same time as an expedited internal plan appeal; if the matter is not eligible for expedited review, the enrollee may request an internal plan appeal, and upon receipt of an adverse appeal determination, has 4 months to request an external appeal. The enrollee and the plan may jointly agree to waive the internal plan appeal process and go directly to external appeal. The MCO's contract with the state describes the MCO's responsibility to inform enrollees of when they have the right to external appeal and how to exercise that right.; that these instructions are included in the NOD (initial adverse determination). An expedited external appeal is resolved in 72 hours or the request; a standard external appeal is resolved in 30 days with a possible extension of up to 5 business days for review of additional information . There is no impact on the enrollee's right to a State Fair Hearing. Once the enrollee has exhausted the MCO's internal appeal process, the enrollee has 120 days to request a State fair hearing. If the enrollee requests both an external appeal and a State fair hearing, the State fair hearing decision supersedes the external appeal decision. The participant is informed of their right to an alternative dispute resolution mechanism and that the dispute resolution mechanism is not a pre-requisite or substitute for a Fair Hearing in the NOD mailed to the participant and when applying for the alternative dispute resolution.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The NYS Department of Health Office of Health Insurance Programs /Division of Health Plan Contracting and Oversight. The Medicaid agency oversees this process through the IMT meeting process.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

NYSDOH maintains a 1-800 number to receive complaints (1-800-206-8125). The OHIP Division of Health Plan Contracting and Oversight operates a complaint system that accepts complaints from enrollees, their designees and providers regarding the access to and quality of care received from an MCO consistent with federal definitions and timelines at 42 CFR 438 subpart F. These complaints are investigated and if an MCO deficiency or concern is identified, the MCO is required to implement a plan of correction. The MCOs are responsible for receiving, reporting, and responding to complaints received from enrollees. The MCOs are required to report the number and category of complaints filed with the MCO by Medicaid enrollees to the NYSDOH at least quarterly. All records including a summary of the grievance, the action taken by the MCO to address the grievance, the final disposition resolution, and dates of all actions are available to the NYSDOH upon request. The MCO's ability to receive and respond appropriately to complaints is reviewed at least every other year during the NYSDOH operational surveys, and more often if concerns are identified to ensure the effectiveness of the MCO's corrective action plan.

OHIP operates a Medicaid Help Line where participants may register complaints which are any expression of dissatisfaction other than an appeal. NYSDOH maintains a 1-800 number to receive complaints (1-800-206-8125) or managedcarecomplaint@health.ny.gov. The OHIP Division of Health Plan Contracting and Oversight operates a complaint system that accepts complaints from enrollees, their designees and providers regarding the access to and quality of care received. The HH policies and procedures include how to manage and report complaints and incidents, and maintain supporting documentation related to the receipt and resolution of complaints and incidents (e.g., steps taken toward resolution, member satisfaction, etc.). HHs must have policies and procedures in place to identify problematic trends in agencies within their partner networks and provide appropriate interventions when corrective actions are needed. Actions must be taken to minimize the probability of recurrence. Such actions must be documented and available for review by the New York State Department of Health (NYSDOH). When a grievance cannot be resolved to the members satisfaction within 90 days the member may escalate complaints and grievances to the Medicaid Help Line or through their Managed Care Plans grievance and complaint procedure. Once resolved, HH or NYSDOH will respond to the child/family by phone or in writing. The participant is informed that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing when filing the grievance/complaint in the acknowledgement of the grievance mailed to the participant or on the call when the participant complains.

This report is reviewed during the IMT meeting in order to develop strategies for system improvement as needed. If significant concerns are identified, the NYSDOH or its designee will address an emergent issue regarding a specific provider or participant immediately.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- ○ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ◉ **No. This Appendix does not apply** *(do not complete Items b through e)*

  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

Waiver participants reside in the community or the home of the parent/guardian, who has legal responsibility for them, and attend school or other public activities where legally mandated reporters and/or other concerned persons can notice and report possible issues regarding a participant's care. For instance, under section 413 of the NYS Social Service Law, nurses are named as mandated reporters who have a legal obligation to report abuse or neglect. Enactment of "Xctasy's Law" includes Local Department Social Service (LDSS) workers as legally mandated reporters.

NYS has other supports in place, such as the statewide Child Abuse Hotline, to assist parents/guardians, teachers and social service workers report concerns for a child's health and safety.

The New York State Department of Health (the Department) is responsible for the oversight of the 1915(c) Children's waiver. OHIP staff will collate all reports of instances of incidents where there is an event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of a Children's waiver participant. This includes all reports from Health Homes and reports from the 1-800 number NYSDOH maintains to receive complaints (1-800-206-8125) or managedcarecomplaint@health.ny.gov. NYS has other supports in place, such as the statewide Child Abuse Hotline, to assist parents/guardians, teachers and social service workers report concerns for a child's health and safety.

The OHIP is responsible for the day-to-day operation and oversight of the Children's FFS and managed care delivery system. This includes MCO contracts and oversight of Health Home program, including standards requirements and roles and responsibilities.

DOH OHIP in conjunction with other DOH divisions assesses the performance of the contractors participation in a variety of ways. The summary of DOH findings from program assessment activities are provided in the annual 372 narrative. DOH has regular meetings with the MCOs, Independent Entity, and Health Homes to discuss FFS reports, fiscal and program data and HCBS assurance data. NYSDOH OHIP staff oversee and monitor the administration of the Children's waiver through annual case record reviews designed to assess the MCO/Health Home/Independent Entity understanding of its role and responsibilities, and waiver administrative processes. Once the applicant is enrolled in the Children's waiver, NYSDOH staff oversees and monitors the administration of the Children's waiver through annual case record reviews designed to assess the waiver functions.

NY implemented the Incident Reporting and Management System (IRAMS) in April 1, 2021. The new system allows HHCM, along with HCBS providers, to submit all reportable incidents to DOH electronically, replacing the outdated paper reporting methods. The new system also helps ensure all necessary information is reported and allows for data capture, aggregation, and analysis, improving DOH's ability to identify any trends and make systemic intervention recommendations based on those trends.

MCO: The majority of children will be served by MCOs who are mandated to maintain critical incident identification, tracking and resolution processes. In the children's plan standards requirements, MCOs are required to separately track critical incident reporting related to children's populations and service covered for children including HCBS services under this waiver. See contract standard 10.38. The MCO must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its Enrollees in receipt of Long Term Services and Supports on a continuous basis. Such mechanisms will include, at a minimum:
i) A process to include information in education materials distributed to Enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for Enrollee assistance;
ii) provisions in subcontracts to ensure providers of long term services and supports comply with State requirements for worker criminal background checks; iii) identification of critical incidents, including but not limited to: wrongful death, restraints, and medication errors resulting in injury, which are brought to the MCO's attention, and subsequent investigation or referral of the incidents to oversight agencies; and iv) reporting critical incidents to NYSDOH. All MCO clinical staff must be trained on reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances, foster care) within 30 days of hire.

All MCOs must provide a report of critical incidents identified and/or investigated by the Contractor involving Enrollees in receipt of long term services and supports. The report goes to SDOH on a quarterly basis, in a manner and format determined by SDOH.

FFS: For Children in the FFS delivery system, there is a process in place for HHCM to elicit information on the

health and welfare of individuals served through the program and for reporting incidents of abuse, neglect, exploitation, or other concerns. At a minimum, the HHCM must maintain face to face contact with the waiver participant and his or her family consistent with the acuity of the child and the HH contact schedule. Contacts may occur in the child's home, school, or other appropriate location. The purpose of the contact is to provide ongoing support, advocacy and follow-up to assure appropriate service delivery for the child and family. During these contacts, possible abuse, neglect, and exploitation may be identified, documented and referred to the appropriate entity for resolution.

Note: the use of telehealth meeting HIPAA privacy requirements (Health Insurance Portability and Accountability Act of 1996) may be utilized for care management to monitor health and welfare as provided for in statute, State regulations and policy.

HH: The New York State Department of Health (the Department) is responsible for the oversight of Health Homes (HH), a care management service model which ensures all of the professionals involved in a member´s care communicate with one another so that the member's medical, behavioral health (mental health and/or substance use disorders), and social service needs are addressed in a comprehensive manner. A reportable incident by a provider is an event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of the member.

Health Home policies and procedures must mandate that the CM inform the HH of a reportable incident by a provider within 24 hours of notification or discovery (or where applicable, by the next business day), including the known facts and circumstances of the incident, the member’s enrollment date, last contact date and type, and current location, if known. The following is a list of reportable incidents.
1. Allegation of abuse, including • Physical abuse • Psychological abuse • Sexual abuse/sexual contact • Neglect • Misappropriation of member funds
2. Suicide attempt
3. Death
4. Crime Level 1
5. Missing person
6. Violation of Protected Health Information (PHI)

The HH must inform the Department within 24 hours of notification from the CM (or where applicable, by the next business day), any reportable incident listed above, along with initial findings. At a minimum, the HH must immediately review the facts and circumstances of the current incident with the CM, along with all pertinent information and incident reports. The HH will provide oversight and direction to the CM to ensure member safety and well-being as well as program integrity, overall programmatic expectations, and compliance with Health Home Standards.

The Department will review the incident reported by the HH and make recommendations, if necessary, to ensure that the Health Home’s reportable incident policy is appropriate and in compliance with established HH Standards. The Department will require HHs to submit, on a quarterly basis, the total number of reports in each of the categories noted on the Health Home Reportable Incident Form, due by the 10th business day after the end of the quarter: • January – March, due April; • April – June, due July; • July – September, due October; and • October – December, due January.

Note: the use of telehealth meeting HIPAA privacy requirements (Health Insurance Portability and Accountability Act of 1996) may be utilized for care management to monitor health and welfare as provided for in statute, State regulations and policy. Waiver participants reside in the community or the home of the parent/guardian, who has legal responsibility for them, and attend school or other public activities where legally mandated reporters and/or other concerned persons can notice and report possible issues regarding a participant’s care. For instance, under section 413 of the NYS Social Service Law, nurses are named as mandated reporters who have a legal obligation to report abuse or neglect. Enactment of "Xctasy's Law" includes Local Department Social Service (LDSS) workers as legally mandated reporters.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines

for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Appendix G-1-a Continued:
The OHIP managed care staff are responsible for the day-to-day operation and oversight of the Children's MC delivery system and are accordingly responsible for assessing the performance of the MCO waiver administration which includes the roles and responsibilities of Health Homes contracted by MCOs. The State's External Quality Review Organization will perform managed care reviews including calculation and/or validation of performance measures per federal requirements at 42 CFR 438 subpart E.

Health Home are also required to submit summaries of reported participant complaints or dissatisfaction with services or providers of services in addition to incidents such as reportable incidents. These reports and records are used to assess waiver administrative performance. Health Home Care Managers and MCOs will track and trend complaints/grievances and reportable incidents received and resolve those issues consistent with contractual requirements and federal regulations. This process is ongoing, not limited to quarterly reports made to NYSDOH. Health Homes and MCOs are responsible for investigating and responding to complaints and incidents that are received.

DOH staff receives a copy of complaint/incidents and conferences with the Health Home to ensure proper investigation is done according to established procedures. NYSDOH staff will hold conference calls with the Health Home/MCO and the complainant if NYSDOH staff determines that the situation warrants it. NYSDOH staff participate in a variety of activities to provide technical assistance in order to maintain an open line of communication with the Health Home/MCO and investigate complaints/incidents. For example, quarterly conference call meetings with the Health Home/MCO staff statewide, provide opportunities for information updates and discussion of issues to ensure consistency in policy interpretation and implementation. Minutes of the meetings are sent to all Health Home/MCO staff. NYSDOH staff participate in training and other meetings such as the statewide Health Home meetings. These meetings provide an opportunity for information and feedback about administrative issues, encourage discussion of common concerns and interests, and development of corrective activities that directly impact the Children's waiver.

NYSDOH maintains a 1-800 number to receive complaints (1-800-206-8125). The MCOs also have required under 438 Subpart F to maintain a complaint and Grievance system outlined in Appendix F of this document as well as the incident reporting required in 10.38 of the MCO contract.
See Appendix G-2-a for the remainder.

Appendix G-2-a Begins below:

The vast majority of children will be served by MCOs for acute care and HCB services who are mandated to maintain critical incident identification, tracking and resolution processes including restraints. In the children's plan standards requirements, MCOs are required to separately track critical incident reporting related to children's populations and service covered for children including HCBS services under this waiver. See contract standard 10.38. The MCO must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its Enrollees in receipt of Long Term Services and Supports on a continuous basis. Such mechanisms will include, at a minimum: i) A process to include information in education materials distributed to Enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for Enrollee assistance; ii) provisions in subcontracts to ensure providers of long term services and supports comply with State requirements for worker criminal background checks; iii) identification of critical incidents, including but not limited to: wrongful death, restraints, and medication errors resulting in injury, which are brought to the MCO's attention, and subsequent investigation or referral of the incidents to oversight agencies; and iv) reporting critical incidents to NYSDOH.
All MCO clinical staff must be trained on reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances, foster care) within 30 days of hire.

Waiver participants live at home or in the community primarily with their parent/legal guardian who have primary legal responsibility for their health and welfare. The HHCM are responsible for detecting unauthorized use of restraints and/or seclusion through face-to-face visits, routine contacts with the participants, and possibly through complaints/grievances or incident reporting. The HHCM are responsible for the overseeing the waiver participants and assuring their health, safety, and welfare. HHCM regularly monitor participant health and welfare during face-to-face contact performed according to the child's acuity and the HH contact schedule. HHCM and HCBS providers are mandated reporters for child abuse to the New York Statewide Central Register of Child Abuse and

Maltreatment. The HHCM takes reports about use of restraint or seclusion from parents or other staff and reports to New York Statewide Central Register of Child Abuse and Maltreatment. If the call is accepted, the LDSS Child Protective Services staff investigates and takes any necessary actions.

The New York State Department of Health (the Department) is responsible for the oversight of Health Homes (HH), a care management service model which ensures all of the professionals involved in a member´s care communicate with one another so that the member's medical, behavioral health (mental health and/or substance use disorders), and social service needs are addressed in a comprehensive manner. A reportable incident is an event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of the member.

Health Home policies and procedures must mandate that the CM inform the HH of a reportable incident within 24 hours of notification or discovery (or where applicable, by the next business day), including the known facts and circumstances of the incident, the member’s enrollment date, last contact date and type, and current location, if known. The following is a list of reportable incidents.
1. Allegation of abuse, including • Physical abuse • Psychological abuse • Sexual abuse/sexual contact • Neglect • Misappropriation of member funds
2. Suicide attempt
3. Death
4. Crime Level 1
5. Missing person
6. Violation of Protected Health Information (PHI)

The HH must inform the Department within 24 hours of notification from the CM (or where applicable, by the next business day), any reportable incident listed above, along with initial findings. At a minimum, the HH must immediately review the facts and circumstances of the current incident with the CM, along with all pertinent information and incident reports. The HH will provide oversight and direction to the CM to ensure member safety and well-being as well as program integrity, overall programmatic expectations, and compliance with Health Home Standards.

The Department will review the incident reported by the HH and make recommendations, if necessary, to ensure that the Health Home’s reportable incident policy is appropriate and in compliance with established HH Standards. The Department will require HHs to submit, on a quarterly basis, the total number of reports in each of the categories noted on the Health Home Reportable Incident Form, due by the 10th business day after the end of the quarter: • January – March, due April; • April – June, due July; • July – September, due October; and • October – December, due January.

Note: the use of telehealth meeting HIPAA privacy requirements (Health Insurance Portability and Accountability Act of 1996) may be utilized for care management to monitor health and welfare as provided for in statute, State regulations and policy. Waiver participants reside in the community or the home of the parent/guardian, who has legal responsibility for them, and attend school or other public activities where legally mandated reporters and/or other concerned persons can notice and report possible issues regarding a participant’s care. For instance, under section 413 of the NYS Social Service Law, nurses are named as mandated reporters who have a legal obligation to report abuse or neglect. Enactment of "Xctasy's Law" includes Local Department Social Service (LDSS) workers as legally mandated reporters.

The OHIP is responsible for the day-to-day operation and oversight of the Children’s FFS and managed care delivery system. This includes the Independent Entity and oversight of Health Home program, including standards requirements and roles and responsibilities.

DOH OHIP in conjunction with other DOH divisions assesses the performance of the contractors participation in a variety of ways. The summary of DOH findings from program assessment activities are provided in the annual 372 narrative. DOH has regular meetings with the Independent Entity, and Health Homes to discuss FFS reports, fiscal and program data and HCBS assurance data.

NYSDOH OHIP staff oversee and monitor the administration of the Children’s waiver through annual case record reviews designed to assess the

Health Home/Independent Entity understanding of its role and responsibilities, and waiver administrative processes. Once the applicant is enrolled in the Children's waiver, NYSDOH staff oversees and monitors the administration of the Children's waiver through annual case record reviews designed to assess the waiver functions.

Health Homes are also required to submit summaries of reported participant complaints or dissatisfaction with services or providers of services in addition to incidents such as reportable incidents. These reports and records are used to assess waiver administrative performance. Health Home Care Managers will track and trend complaints/grievances and reportable incidents received and resolve those issues consistent with contractual requirements and federal regulations. This process is ongoing, not limited to quarterly reports made to NYSDOH. Health Homes and the IE are responsible for investigating and responding to complaints and incidents that are received.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G-2-a Continued begins Below:

DOH staff receives a copy of complaint/incidents and conferences with the Health Home to ensure proper investigation is done according to established procedures. NYSDOH staff will hold conference calls with the Health Home and the complainant if NYSDOH staff determines that the situation warrants it. NYSDOH staff participate in a variety of activities to provide technical assistance in order to maintain an open line of communication with the Health Home and investigate complaints/incidents. For example, quarterly conference call meetings with the Health Home staff statewide, provide opportunities for information updates and discussion of issues to ensure consistency in policy interpretation and implementation. Minutes of the meetings are sent to all Health Home staff. NYSDOH staff participate in training and other meetings such as the statewide Health Home meetings. These meetings provide an opportunity for information and feedback about administrative issues, encourage discussion of common concerns and interests, and development of corrective activities that directly impact the Children's waiver.

NYSDOH maintains a 1-800 number to receive complaints (1-800-206-8125).

Interagency Monitoring Team (IMT), chaired by NYSDOH staff, with representation from State children's services agencies will collect the reports outlined in the waiver application and review at least quarterly to ensure that the specialized needs of various populations included within the Children's waiver are met. DOH and the Interagency Monitoring Team will review issues as outlined in Appendix H as well as providing DDRO and LDSS, and FMS oversight as needed.
See Appendix G-2-b for the remainder.

Appendix G-2-b begins below:

Any staff person or family member who observes a use of restrictive intervention must report it immediately according to MCO critical incident reporting and agency protocol.

The vast majority of children will be served by MCOs for HCBS and acute care services who are mandated to maintain critical incident identification, tracking and resolution processes including identification of use of restrictive interventions. In the children's plan standards requirements, MCOs are required to separately track critical incident reporting related to children's populations and service covered for children including HCBS services under this waiver. See contract standard 10.38. The MCO must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its Enrollees in receipt of Long Term Services and Supports on a continuous basis. Such mechanisms will include, at a minimum: i) A process to include information in education materials distributed to Enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for Enrollee assistance; ii) provisions in subcontracts to ensure providers of long term services and supports comply with State requirements for worker criminal background checks; iii) identification of critical incidents, including but not limited to: wrongful death, restraints, and medication errors resulting in injury, which are brought to the MCO's attention, and subsequent investigation or referral of the incidents to oversight agencies; and iv) reporting critical incidents to NYSDOH.
All MCO clinical staff must be trained on reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances, foster care) within 30 days of hire.

Waiver participants live at home or in the community primarily with their parent/legal guardian who have primary legal responsibility for their health and welfare. The HHCM are responsible for detecting unauthorized use of restrictive interventions through face-to-face visits, routine contacts with the participants, and possibly through complaints/grievances or incident reporting. The HHCM are responsible for the overseeing the waiver participants and assuring their health, safety, and welfare. HHCM regularly monitor participant health and welfare during face-to-face contact performed according to the child's acuity and the HH contact schedule. HHCM and HCBS providers are mandated reporters for child abuse to the New York Statewide Central Register of Child Abuse and Maltreatment. The HHCM takes reports about use of restraint or seclusion from parents or other staff and reports to New York Statewide Central Register of Child Abuse and Maltreatment. If the call is accepted, the LDSS Child Protective Services staff investigates and takes any necessary actions.

NYSDOH is responsible for oversight through HH annual reviews. The New York State Department of Health (the Department) is responsible for the oversight of Health Homes (HH), a care management service model which

ensures all of the professionals involved in a member´s care communicate with one another so that the member's medical, behavioral health (mental health and/or substance use disorders), and social service needs are addressed in a comprehensive manner. A reportable incident is an event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of the member.

Health Home policies and procedures must mandate that the CM inform the HH of a reportable incident within 24 hours of notification or discovery (or where applicable, by the next business day), including the known facts and circumstances of the incident, the member's enrollment date, last contact date and type, and current location, if known. The following is a list of reportable incidents.
1. Allegation of abuse, including • Physical abuse • Psychological abuse • Sexual abuse/sexual contact • Neglect • Misappropriation of member funds
2. Suicide attempt
3. Death
4. Crime Level 1
5. Missing person
6. Violation of Protected Health Information (PHI)

The HH must inform the Department within 24 hours of notification from the CM (or where applicable, by the next business day), any reportable incident listed above, along with initial findings. At a minimum, the HH must immediately review the facts and circumstances of the current incident with the CM, along with all pertinent information and incident reports. The HH will provide oversight and direction to the CM to ensure member safety and well-being as well as program integrity, overall programmatic expectations, and compliance with Health Home Standards.

The Department will review the incident reported by the HH and make recommendations, if necessary, to ensure that the Health Home's reportable incident policy is appropriate and in compliance with established HH Standards. The Department will require HHs to submit, on a quarterly basis, the total number of reports in each of the categories noted on the Health Home Reportable Incident Form, due by the 10th business day after the end of the quarter: • January – March, due April; • April – June, due July; • July – September, due October; and • October – December, due January.

Note: the use of telehealth meeting HIPAA privacy requirements (Health Insurance Portability and Accountability Act of 1996) may be utilized for care management to monitor health and welfare as provided for in statute, State regulations and policy. Waiver participants reside in the community or the home of the parent/guardian, who has legal responsibility for them, and attend school or other public activities where legally mandated reporters and/or other concerned persons can notice and report possible issues regarding a participant's care. For instance, under section 413 of the NYS Social Service Law, nurses are named as mandated reporters who have a legal obligation to report abuse or neglect. Enactment of "Xctasy's Law" includes Local Department Social Service (LDSS) workers as legally mandated reporters.

The OHIP is responsible for the day-to-day operation and oversight of the Children's FFS and managed care delivery system. This includes the Independent Entity and oversight of Health Home program, including standards requirements and roles and responsibilities.

DOH OHIP in conjunction with other DOH divisions assesses the performance of the contractors participation in a variety of ways. The summary of DOH findings from program assessment activities are provided in the annual 372 narrative. DOH has regular meetings with the Independent Entity, and Health Homes to discuss FFS reports, fiscal and program data and HCBS assurance data.

NYSDOH OHIP staff oversee and monitor the administration of the Children's waiver through annual case record reviews designed to assess the
Health Home/Independent Entity understanding of its role and responsibilities, and waiver administrative processes. Once the applicant is enrolled in the Children's waiver, NYSDOH staff oversees and monitors the administration of the Children's waiver through annual case record reviews designed to assess the waiver functions.

Health Homes are also required to submit summaries of reported participant complaints or dissatisfaction with

services or providers of services in addition to incidents such as reportable incidents. These reports and records are used to assess waiver administrative performance. Health Home Care Managers will track and trend complaints/grievances and reportable incidents received and resolve those issues consistent with contractual requirements and federal regulations. This process is ongoing, not limited to quarterly reports made to NYSDOH. Health Homes are responsible for investigating and responding to complaints and incidents that are received.

DOH staff receives a copy of complaint/incidents and conferences with the Health Home to ensure proper investigation is done according to established procedures. NYSDOH staff will hold conference calls with the Health Home and the complainant if NYSDOH staff determines that the situation warrants it. NYSDOH staff participate in a variety of activities to provide technical assistance in order to maintain an open line of communication with the Health Home and investigate complaints/incidents. For example, quarterly conference call meetings with the Health Home staff statewide, provide opportunities for information updates and discussion of issues to ensure consistency in policy interpretation and implementation. Minutes of the meetings are sent to all Health Home staff. NYSDOH staff participate in training and other meetings such as the statewide Health Home meetings. These meetings provide an opportunity for information and feedback about administrative issues, encourage discussion of common concerns and interests, and development of corrective activities that directly impact the Children's waiver.

NYSDOH maintains a 1-800 number to receive complaints (1-800-206-8125).

Interagency Monitoring Team (IMT), chaired by NYSDOH staff, with representation from State children's services agencies will collect the reports outlined in the waiver application and review at least quarterly to ensure that the specialized needs of various populations included within the Children's waiver are met. DOH and the Interagency Monitoring Team will review issues as outlined in Appendix H as well as providing FMS, DDRO and LDSS oversight as needed.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The vast majority of children will be served by MCOs for acute care and HCBS who are mandated to maintain critical incident identification, tracking and resolution processes including use of seclusion. In the children's plan standards requirements, MCOs are required to separately track critical incident reporting related to children's populations and service covered for children including HCBS services under this waiver. See contract standard 10.38. The MCO must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its Enrollees in receipt of Long Term Services and Supports on a continuous basis. Such mechanisms will include, at a minimum: i) A process to include information in education materials distributed to Enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for Enrollee assistance; ii) provisions in subcontracts to ensure providers of long term services and supports comply with State requirements for worker criminal background checks; iii) identification of critical incidents, including but not limited to: wrongful death, restraints, and medication errors resulting in injury, which are brought to the MCO's attention, and subsequent investigation or referral of the incidents to oversight agencies; and iv) reporting critical incidents to NYSDOH.

All MCO clinical staff must be trained on reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances, foster care) within 30 days of hire.

Waiver participants live at home or in the community primarily with their parent/legal guardian who have primary legal responsibility for their health and welfare. The HHCM are responsible for detecting unauthorized use of restraints and/or seclusion through face-to-face visits, routine contacts with the participants, and possibly through complaints/grievances or incident reporting. The HHCM are responsible for the overseeing the waiver participants and assuring their health, safety, and welfare. HHCM regularly monitor participant health and welfare during face-to-face contact performed according to the child's acuity and the HH contact schedule. HHCM and HCBS providers are mandated reporters for child abuse to the New York Statewide Central Register of Child Abuse and Maltreatment. The HHCM takes reports about use of restraint or seclusion from parents or other staff and reports to New York Statewide Central Register of Child Abuse and Maltreatment. If the call is accepted, the LDSS Child Protective Services staff investigates and takes any necessary actions.

The New York State Department of Health (the Department) is responsible for the oversight of Health Homes (HH), a care management service model which ensures all of the professionals involved in a member´s care communicate with one another so that the member's medical, behavioral health (mental health and/or substance use disorders), and social service needs are addressed in a comprehensive manner. A reportable incident is an event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of the member.

Health Home policies and procedures must mandate that the CM inform the HH of a reportable incident within 24 hours of notification or discovery (or where applicable, by the next business day), including the known facts and circumstances of the incident, the member's enrollment date, last contact date and type, and current location, if known. The following is a list of reportable incidents.
1. Allegation of abuse, including • Physical abuse • Psychological abuse • Sexual abuse/sexual contact • Neglect • Misappropriation of member funds
2. Suicide attempt
3. Death
4. Crime Level 1
5. Missing person
6. Violation of Protected Health Information (PHI)

The HH must inform the Department within 24 hours of notification from the CM (or where applicable, by the next business day), any reportable incident listed above, along with initial findings. At a minimum, the HH must immediately review the facts and circumstances of the current incident with the CM, along with all pertinent information and incident reports. The HH will provide oversight and direction to the CM to ensure member safety and well-being as well as program integrity, overall programmatic expectations, and compliance with Health Home Standards.

The Department will review the incident reported by the HH and make recommendations, if necessary, to ensure that the Health Home's reportable incident policy is appropriate and in compliance with established HH Standards. The Department will require HHs to submit, on a quarterly basis, the total number of reports in each of the categories noted on the Health Home Reportable Incident Form, due by the 10th business day after the end of the

quarter: • January – March, due April; • April – June, due July; • July – September, due October; and • October – December, due January.

Note: the use of telehealth meeting HIPAA privacy requirements (Health Insurance Portability and Accountability Act of 1996) may be utilized for care management to monitor health and welfare as provided for in statute, State regulations and policy. Waiver participants reside in the community or the home of the parent/guardian, who has legal responsibility for them, and attend school or other public activities where legally mandated reporters and/or other concerned persons can notice and report possible issues regarding a participant's care. For instance, under section 413 of the NYS Social Service Law, nurses are named as mandated reporters who have a legal obligation to report abuse or neglect. Enactment of "Xctasy's Law" includes Local Department Social Service (LDSS) workers as legally mandated reporters.

The OHIP is responsible for the day-to-day operation and oversight of the Children's FFS and managed care delivery system. This includes the Independent Entity and oversight of Health Home program, including standards requirements and roles and responsibilities.

DOH OHIP in conjunction with other DOH divisions assesses the performance of the contractors participation in a variety of ways. The summary of DOH findings from program assessment activities are provided in the annual 372 narrative. DOH has regular meetings with the Independent Entity, and Health Homes to discuss FFS reports, fiscal and program data and HCBS assurance data.

NYSDOH OHIP staff oversee and monitor the administration of the Children's waiver through annual case record reviews designed to assess the
Health Home/Independent Entity understanding of its role and responsibilities, and waiver administrative processes. Once the applicant is enrolled in the Children's waiver, NYSDOH staff oversees and monitors the administration of the Children's waiver through annual case record reviews designed to assess the waiver functions.

Health Homes are also required to submit summaries of reported participant complaints or dissatisfaction with services or providers of services in addition to incidents such as reportable incidents. These reports and records are used to assess waiver administrative performance. Health Home Care Managers will track and trend complaints/grievances and reportable incidents received and resolve those issues consistent with contractual requirements and federal regulations. This process is ongoing, not limited to quarterly reports made to NYSDOH. Health Homes are responsible for investigating and responding to complaints and incidents that are received.

DOH staff receives a copy of complaint/incidents and conferences with the Health Home to ensure proper investigation is done according to established procedures. NYSDOH staff will hold conference calls with the Health Home and the complainant if NYSDOH staff determines that the situation warrants it. NYSDOH staff participate in a variety of activities to provide technical assistance in order to maintain an open line of communication with the Health Home and investigate complaints/incidents. For example, quarterly conference call meetings with the Health Home staff statewide, provide opportunities for information updates and discussion of issues to ensure consistency in policy interpretation and implementation. Minutes of the meetings are sent to all Health Home staff. NYSDOH staff participate in training and other meetings such as the statewide Health Home meetings. These meetings provide an opportunity for information and feedback about administrative issues, encourage discussion of common concerns and interests, and development of corrective activities that directly impact the Children's waiver.

NYSDOH maintains a 1-800 number to receive complaints (1-800-206-8125).

Interagency Monitoring Team (IMT), chaired by NYSDOH staff, with representation from State children's services agencies will collect the reports outlined in the waiver application and review at least quarterly to ensure that the specialized needs of various populations included within the Children's waiver are met. DOH and the Interagency Monitoring Team will review issues as outlined in Appendix H as well as providing DDRO, LDSS, and FMS oversight as needed.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established

concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Waiver participants in Foster Care living in homes (foster homes, kinship homes or their own homes) must be monitored regarding their ability to self-administer medications. Upon admission into the waiver, every six months and as necessary, the foster care worker gathers information regarding the child's ability to self-administer medications. If problems are identified, the child and family/caregiver are referred to an appropriate service provider for an assessment and/or training and assistance so that safe management of the child's medication will occur. An appropriate service provider may include providers of Medicaid State Plan services, other local, State or Federal program providers or a waiver services provider. In some instances, informal supports may be utilized. All waiver staff is responsible for reporting cognitive, physical and/or behavioral changes to the foster care worker which may require intervention. Children residing in foster boarding homes are under the supervision of trained foster parents. These parents provide routine care to children, including medication administration.

Each child in an agency operated boarding home (AOBH) or group home setting must have an Individual Medication Plan (IMP) maintained in the child's medical record and accessible to staff who administer medication to that child. The IMP is developed at the initial comprehensive health assessment by a licensed medical practitioner and reviewed and updated at least annually and whenever there is a change. The IMP shall include the condition or diagnosis for which a prescribed or over-the-counter medication is to be used, medication name, dosage and route of administration, the frequency of administration, monitoring standards for each medication, the child's capability to self-administer medication, and specific instructions related to the medication. An individual Medication Administration Record (MAR) will also be maintained in the child's medical record and made accessible to staff who administer medication to that child. The MAR must include the date and time that each dose is administered and the initials of the individual who administered, assisted or supervised the self-administration of the medication. The MAR must also include documentation of medication errors, actions taken, and effects of the errors.

A determination must be made for each child receiving medication in an AOBH or group home as to the child's ability to self-administer medication. The determination of the child's ability to self-administer medication is made by the prescribing physician in conjunction with the child's treatment team. Any such determination must be documented in the child's medical record.

All authorized agencies that provide AOBH or group home care for children in foster care must use the services of a licensed medical practitioner to oversee all aspects of medication administration in those settings. These include but are not limited to: reviewing the prescribing practitioner's medication orders; reviewing medications received from pharmacies for accuracy and compliance with orders; reviewing medication administration records for accuracy, timeliness, and compliance with orders; working with trained staff in the administration of medication to children; directing the storage and handling of medication in accordance with applicable statutes; reviewing the content and provision of medication training for agency staff; and overseeing the maintenance of each child's IMP and MAR.

During the time frame that a child is in foster care, second-line monitoring is provided by the LDSS' case manager, at minimum, every six (6) months at Service Plan Reviews and the voluntary agency's case planner on a more frequent, routine basis, tailored to the individual child. Second-line monitoring detects potentially harmful practices through observation of the child and dialogue with the child's caregivers. When concerns are identified, the prescribing medical professionals engage in determining further action to be taken. As needed, additional training is provided to the child and the child's caregivers, as appropriate.

The Individual Medication Plan is monitored at least annually and whenever there is an update/ change or new prescribing practitioner's medication order. In addition the Individual Medication Plan is monitored by a licensed medical practitioner and would include behavior modifying medications.

The foster care worker and the HHCM works with medical providers to ensure open communication regarding any changes/needs in the child's behaviors.

Second-line monitoring is conducted in the same way for all medication including behavior modifying medications.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that

participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

AOBHs and group homes are licensed and monitored by OCFS who is ultimately each child's guardian. OCFS has specific regulations to file regarding medication management and medication assistance for children in AOBHs and group homes. These regulations require that child caring agencies must have written policies and procedures to address the safe and effective administration of medication and require OCFS to review and approve each agency's policies. Policies must address: communication, documentation, and staffing requirements for safe and effective medication management; procedures for medication administration when the child is offsite, including home visits and school; procedures and safeguards for the use of 'as needed' and over- the-counter medications; procedures and safeguards to prevent medication errors; a plan for training staff involved in administering, assisting and supervising the self-administration of medication. Training includes written and skills competency tests, and annual updates. OCFS conducts periodic reviews, at a minimum once every three years, of agencies that include an evaluation of compliance with the policies for administration of medication.

All authorized agencies that provide agency operated boarding home or group home care for children in foster care must use the services of a licensed medical practitioner to oversee all aspects of medication administration in those settings. These include but are not limited to: reviewing the prescribing practitioner's medication orders; reviewing medications received from pharmacies for accuracy and compliance with orders; reviewing medication administration records for accuracy, timeliness, and compliance with orders; working with trained staff in the administration of medication to children; directing the storage and handling of medication in accordance with applicable statutes; reviewing the content and provision of medication training for agency staff; and overseeing the maintenance of each child's Individual Medication Plan and Medication Administration Record.

OCFS is the state agency responsible for direct oversight of Agency Operated Boarding Homes (AOBHs) and group homes. OCFS monitors the AOBHs and group homes and is ultimately each child's guardian.

However, DOH is the State agency responsible for licensing these types of facilities under 29i authority. (Article 29-I of Section 1 of the Public Health Law Section 2999-gg. Voluntary foster care agency health facilities.) DOH has the authority to bring enforcement actions against facilities based on failure to comply with applicable laws and/or regulations following a survey or the investigation of an incident or complaint. Enforcement actions include revocation, suspension, limiting, annulling, or denial of a licensed of an authorized agency to provide limited health-related services or of any imposition of a civil penalty against such entity. DOH and OCFS have a memorandum of understanding regarding the provision of services under 29i.

OCFS is required through the MOU with DOH to notify DOH immediately of any situations in which OCFS suspects a provider's alleged noncompliance a requirement caused harm or may have the potential for placing patients in harm upon having knowledge of such harm or in situations. This includes notification of the DOH Office of Professional Medical Conduct, Office of the Medicaid Inspector General or the State Education Department Office of the Professions of any 29i licensee that OCFS believes may be in non-compliance with laws and/or regulations. The OCFS must also notify DOH of findings relating from any investigations carried out by OCFS on DOH's behalf due to complaints and making recommendations to DOH regarding enforcement actions to be taken by DOH. OCFS must also notify DOH of its intent to limit, revoke or suspend approval of an authorized agency to operate a foster care program or an operating certificate of a facility caring for foster care that may impact the 29i certificate of a facility and of the surrender of an operating certificate by an authorized agency. OCFS must notify DOH if it intends to assign responsibilities to another contractor.

OCFS conducts on-site inspections of authorized agencies that have applied to become licensed by the DOH to provide limited health-related services in accordance with the process and monitoring tools developed by OCFS and approved by DOH with the technical assistance of DOH as needed. OCFS investigates complaints/incidents in accordance with accordance with the process and monitoring tools developed by OCFS and approved by DOH with the technical assistance of DOH as needed. On-site inspections occur every three years or when a complaint/incident is received.

The MOU outlines that OCFS and DOH will share surveillance information, including but not limited to, survey findings, complaint allegations and incident reports, such that DOH may provide the technical assistance and enforcement action obligation.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- (●) **Not applicable.** *(do not complete the remaining items)*
- ( ) **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

Do not complete the rest of this section

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ( ) **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the state:

- ( ) **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

  Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed

and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # and % of substantiated cases of abuse, neglect, exploitation, and unexplained deaths through recommended and implemented actions to protect the participants health and welfare (N # of substantiated cases of abuse, neglect, exploitation, and unexplained deaths through recommended and implemented actions/D Total # of substantiated cases of abuse, neglect, exploitation, and unexplained death

Data Source (Select one):
Other
If 'Other' is selected, specify:
IRAMS; MCO Critical Incident Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Number and percent of reports related to abuse, neglect, exploitation, and unexplained death of participants reported within the required timelines (N Number of reports related to abuse, neglect, exploitation, and unexplained death of participants reported within the required timelines / D Total reports related to abuse, neglect, exploitation and unexplained death of participants)

Data Source (Select one):
Other
If 'Other' is selected, specify:
IRAMS; MCO Critical Incident Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants enrolled who have contact with their care manager consistent with the waiver guidelines (N Number of waiver participants enrolled who have contact with their care manager consistent with the waiver guidelines / D Total waiver participants reviewed)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = CI=95% +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of MCOs that report critical incidents via their critical identification, tracking and resolution processes (N Number of MCOs that report critical incidents via their critical incident identification, tracking and resolution processes / D Total MCOs)

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Critical Incident Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency designee (NYSTEC)	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who received information on how to report suspected abuse, neglect, exploitation, or unexplained death according to policy (N Number of participants who received information on how to report suspected abuse, neglect, exploitation, or unexplained death according to policy / D Total participants reviewed)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = CI=95% +/- 5% margin of error
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of critical incidents that were reported, reviewed, and submitted to DOH within required timeframes, as specified in the approved waiver (N Number of critical incidents that were reported, reviewed, and submitted to DOH within required timeframes, as specified in the approved waiver / D Total reported critical incidents)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of critical incident trends where systemic intervention was implemented. (N Number of critical incident trends where systemic intervention was implemented / D Total number of critical incident trends)

Data Source (Select one):
Other
If 'Other' is selected, specify:
IRAMS; MCO Critical Incident Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and % of systemic interventions implemented, based on recommended interventions from IMT mtg and review of incident data related to ANE & UD of part(N # of systemic interventions implemented, based on recommended interventions from IMT mtg and review of incident data related to ANE & UD of part/D Total # of systemic interventions recommended from IMT mtg and review of incident data)

Data Source (Select one):
Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency designee (NYSTEC)	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver providers with policies and procedures in place that prohibit the use of restrictive interventions, including restraints and seclusion (N Number of waiver providers with policies and procedures in place that prohibit the use of restrictive interventions, including restraints and seclusion / D Total waiver providers)

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
providers policies and procedures

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample**

		Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: with provider redesignation	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: 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.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # and % of CW part who received health care consistent with NY standards (annual physical exams or a wellness exam per guidelines) and NY monitored the service provider per approved waiver (N # of CW part who received health care consistent with NY standards (annual physical exams or a wellness exam per guidelines) and NY monitored the service provider per approved waiver/D Total # of CW part)

Data Source (Select one):
Other
If 'Other' is selected, specify:
FFS Claim & MC Encounter Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Note for Sub-assurance a: OHIP within DOH aggregates the reports for all of the performance measures below from all sources in order to calculate the overall PMs for both the FFS and MCO delivery system. The reporting includes:
1. The statewide State Fair Hearing appeals for waiver participants both in FFS or MC,
2. All MCO reports of appeals of waiver participants
3. The NYSDOH case file reviews for both FFS and MC that validated the participants who received information on how to report suspected abuse, neglect, or exploitation, or unexplained death
4. MCO and FFS reports related to abuse, neglect, and exploitation and unexplained death of participants where an investigation was initiated within the established timelines, and
5. MCO and FFS cases of abuse, neglect and exploitation and unexplained death where recommended actions to protect health and welfare were implemented

The vast majority of children will be served by MCOs providing acute care services and HCBS and who are mandated to maintain critical incident identification, tracking and resolution processes including identification of use of seclusion, restraint and restrictive interventions. In the children's plan standards requirements, MCOs are required to separately track critical incident reporting related to children's populations and service covered for children including HCBS under this

waiver.
See contract standard 10.38. The MCO must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its Enrollees in receipt of Long Term Services and Supports on a continuous basis. Such mechanisms will include, at a minimum: i) A process to include information in education materials distributed to Enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for Enrollee assistance; ii) provisions in subcontracts to ensure providers of long term services and supports comply with State requirements for worker criminal background checks; iii) identification of critical incidents, including but not limited to: wrongful death, restraints, and medication errors resulting in injury, which are brought to the MCO's attention, and subsequent investigation or referral of the incidents to oversight agencies; and iv) reporting critical incidents to NYSDOH. All MCO clinical staff must be trained on reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances, foster care) within 30 days of hire

The protection of waiver participants' health and welfare begins with the HHCM and MCO and at the local level with the LDSS Child Protective Services Unit (CPS). HCBS providers and HHCM are mandated reporters for child abuse under NY state law. The New York State Office of Children and Family Services maintains a New York Statewide Central Register of Child Abuse and Maltreatment for reports made pursuant to New York State Social Services Law. If the call is accepted, the LDSS Child Protective Services staff investigates and takes any necessary actions to protect children from further abuse or maltreatment, and to provide rehabilitative services to children, parents, and other family members.

The HHCM contacts the waiver participant's family at a minimum, on a basis consistent with the participant's acuity and the HH contact schedule. The contact may occur in the child's home or at another location such as the child's school. The purpose of the contact is to provide ongoing support, advocacy, and follow-up for the child and family, including identifying possible abuse, neglect, or exploitation. If one of these problems is identified, it is then documented and referred to the appropriate entity.
These meetings also serve as a vehicle to complete the six month assessment requirement for the waiver program. For children who opt out of HH, the MCO will monitor through quarterly calls and POC reviews (the MCO will monitor the State plan service delivery under their contracts).

NYSDOH staff routinely discuss efforts to prevent abuse, neglect, and exploitation with the HH and MCOs during quarterly statewide conference calls. The aim is to develop enhanced and consistent statewide incident reporting and documentation processes. NYSDOH staff also work with the staff of the HH/MCO to provide waiver participants and their parents/legal guardians with information about mandated incident reporting policies.

Finally NYSDOH, MCO, HH, staff performs an annual statistically significant case record review and evaluation. If any patterns of error are identified, or greater than fifteen percent of reviewed cases are found to be "unsatisfactory", the NYSDOH will take action in the form of further inquiry, assessment of a need for training and/or further evaluation of the Children's administrative system (including the protocol and performance of the care manager). These systemic measures have the underlying purpose of preventing abuse, neglect and exploitation of those in the Children's waiver.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The remediation process is initiated when the MCO/HH or NYSDOH staff or Interagency Monitoring Team identifies health and welfare issue with a child. The vast majority of children will be served by MCOs who are mandated to maintain critical incident identification, tracking and resolution processes. See contract standard.
10.38. In the children's plan standards requirements, MCOs are required to separately track critical incident reporting related to children's populations and service covered for children including HCBS under this waiver. See contract standard 10.38. The MCO must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its Enrollees in receipt of Long Term Services and Supports on a continuous basis. Such mechanisms will include, at a minimum: i) A process to include information in education materials distributed to Enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for Enrollee assistance; ii) provisions in subcontracts to ensure providers of long term services and supports comply with State requirements for worker criminal background checks; iii) identification of critical incidents, including but not limited to: wrongful death, restraints, and medication errors resulting in injury, which are brought to the MCO's attention, and subsequent investigation or referral of the incidents to oversight agencies; and iv) reporting critical incidents to NYSDOH. All MCO clinical staff must be trained on reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances, foster care) within 30

days of hire. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

In such situations, the standard procedure is for NYSDOH staff, MCO, and Interagency Monitoring Team, to discuss the situation and for NYSDOH to issue a statement of deficiency(ies). The HH must provide a plan of correction and address any issues at the child/family level. NYSDOH staff, MCO and the IMT may collaboratively work with the HH to develop a plan of correction, if necessary. Implementation of and compliance with the plan of correction are monitored by NYSDOH and MCO.

If the plan of correction requires a change in the participant's service, NYSDOH staff and the MCO will work cooperatively to address the service deficiency and when necessary, transition the child to another waiver provider. The HHCM will communicate any changes needed to the family and help the family find alternative providers. To ensure continuity of service during the transition period, the original provider will be required to transfer the participant case records and other pertinent documents to the new provider until transition is complete.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide waiver services. The provider may be referred to the licensure or certification agency staff, as needed. Accordingly, NYSDOH staff, or its designee the IMT, will issue a letter to the provider terminating the provider's waiver designation provider status.

After 3/1/2024, the FMS responsible for providing FMS services will identify unsatisfactory vehicle modification, home modification, adaptive and assistive technology and transitional services (effective 1/1/2026) contractors. The FMS will disqualify unsatisfactory contractors and will find alternate contractors when necessary. Unsatisfactory accessibility modification, transitional services, and adaptive and assistive technology contractors will be notified of their disqualification from further service by the administering MCO, FMS, or DDRO and LDSS (through the transition).

Documentation of remediation activities is accomplished by the following measures: correspondence among NYSDOH waiver management staff, MCO staff, the CM, participants' and their parents/legal guardians, and/or service providers; amended plans of care; case reviews and reports of follow-up meetings with participants and their families documented by MCO and HH; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file. Circumstances involving remediation are maintained, as appropriate, by NYSDOH and/or the MCO.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: State Medicaid Agency Designee (NYSTEC)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

  Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Interagency Monitoring Team (IMT) is chaired by NYSDOH staff with representation from State children's licensing, certification, designation and service agencies (OMH, OASAS, OCFS and OPWDD) and collects the reports outlined in the waiver application with review at least quarterly. An interagency agreement outlines oversight roles of IMT partners. NYSDOH and the IMT committee holds the primary responsibility for monitoring and assessing the effectiveness of system and programmatic design changes to determine if the desired effect has been achieved. This includes incorporation of feedback from participants, stakeholders, providers, MCOs, and Health Homes. At IMT meetings, IMT members:
-Track and trend aggregated data and review data including all HCBS performance measures,
-Present and analyze data and information on all delineated performance measures to ensure compliance with state and federal regulations and to identify patterns, trends, and concerns/issues,
-Provide oversight and monitoring of any corrective action plans associated with the administration of the Children's waiver,
-Discuss any provider designation issues, and
-Develop, oversee, and monitor quality assurance/quality improvement initiatives and activities.

NYSDOH and the IMT meet with the MCOs and HH to discuss any identified issues or concerns.

Typically, NYSDOH, in collaboration with the NYS licensing and certification agencies on the IMT, implements system design change to MA waiver programs when there is a clear and strong need has been identified by State and/or local waiver staff or other stakeholders.

Stakeholders have several vehicles with which to voice their concerns, including regional meetings, stakeholder surveys, contact with their Care managers, HCBS providers, MCOs and direct communication with NYSDOH waiver management staff or its designee the IMT. If monitoring review substantiates that a particular issue needs to be addressed, remediation actions are taken. Should the agreed upon remedies not be a satisfactory resolution, further study of the particular waiver element is undertaken. The recommendations of NYSDOH waiver management staff, IMT, HH/MCO, waiver participants, providers and other stakeholders are considered.

Position papers summarizing the findings and analysis are presented to senior NYSDOH managers and its designee the IMT. Recommendations are prioritized by NYSDOH in consultation with the State Medicaid Director and State agency partners on the basis of the scope of the policy, its impact on waiver participants, and the overall ability of the State to accommodate any fiscal impact.

Subsequent recommendations are approved in keeping with programmatic priorities, consumer benefit, and the opportunity for administrative efficiency and system wide reform.

If the system change is accepted but cannot be made administratively, certain measures are recommended and implemented though the established annual NYS budget and legislative process. At this stage, NYSDOH staff, in collaboration with other state agency partners, brief NYS Division of the Budget and Legislative staff, and discuss the proposals with program participants, advocates, providers, and other stakeholders to gain their input and support.

NYSDOH staff and its designee, the IMT, implement system change when authorized by NYSDOH and the Medicaid Director. All MCOs must comply with the provisions in their contracts regarding Quality Assurance and reporting to the state. Each MCO may be required, at the State's option, to conduct an internal performance improvement project (PIP) on a topic affecting the children's populations. Each MCO will separately track, trend, and report complaints, grievances, appeals, and denials related to the children's populations and services including HCBS. For children eligible for HCBS, each MCO's UM BH subcommittee shall separately report, monitor findings and recommend appropriate action on the following additional metrics:

i. Use of crisis diversion and crisis intervention services;
ii. Prior authorization/denial and notices of action;
iii. HCBS utilization;
iv. HCBS quality assurance performance measures as determined by the State and pending CMS requirements; and
v. Enrollment in Health Home.

The foundation of the Children's waiver QIS is built upon discovery through performance metrics, reporting to stakeholders, and systems wide analysis and collaboration that leads to effective remediation strategies, quality of care enhancements, and ultimately mission-driven progress. The DOH construct establishes a series of offices within OHIP that interface with stakeholders and create a framework to develop, monitor and revise quality improvement initiatives throughout the Children's service system in New York State.

DOH leadership will establish priorities for the Children's waiver. OHIP within DOH will guide the system, identify critical areas for improvement, coordinate new and ongoing efforts, and develop strategies to make sure that the system is person-centered and sustainable. OHIP will focus on: transitioning to managed care; achieving transformation goals; and continuing to work with the provider community to find efficiencies and foster innovation.

The Interagency Monitoring Team (IMT) is chaired by NYSDOH staff with representation from State children's licensing, certification, designation and service agencies (OMH, OASAS, OCFS and OPWDD) and collects the reports outlined in the waiver application with review at least quarterly. An interagency agreement outlines oversight roles of IMT partners. NYSDOH and the IMT committee holds the primary responsibility for monitoring and assessing the effectiveness of system and programmatic design changes to determine if the desired effect has been achieved. These meetings review findings, make recommendations for strategies and assess the effectiveness of system improvements on a quarterly basis.

This includes incorporation of feedback from participants, stakeholders, providers, and Health Homes/MCOs. At IMT meetings, IMT members:
-Track and trend aggregated data and review data including all HCBS performance measures,
-Present and analyze data and information on all delineated performance measures to ensure compliance with state and federal regulations and to identify patterns, trends, and concerns/issues,
-Provide oversight and monitoring of any corrective action plans associated with the administration of the Children's waiver,
-Discuss any provider designation issues, and
-Develop, oversee, and monitor quality assurance/quality improvement initiatives and activities.

NYSDOH and the IMT meet with the HHs to discuss any identified issues or concerns using regularly scheduled monthly and quarterly meetings.

Typically, NYSDOH, in collaboration with the NYS licensing and certification agencies on the IMT, implements system design change to MA waiver programs when there is a clear and strong need has been identified by State and/or local waiver staff or other stakeholders.

Stakeholders have several vehicles with which to voice their concerns, including regional meetings, stakeholder surveys, contact with their Care managers, HCBS providers, MCOs and direct communication with NYSDOH waiver management staff or its designee the IMT. If monitoring review substantiates that a particular issue needs to be addressed, remediation actions are taken. Should the agreed upon remedies not be a satisfactory resolution, further study of the particular waiver element is undertaken. The recommendations of NYSDOH waiver management staff, IMT, HH/MCO, waiver participants, providers, and other stakeholders are considered.

Stakeholders will receive information regarding changes through the State's web-site, regularly scheduled quarterly and annual meetings with advocates, regional meetings, direct communication with NYSDOH waiver management staff and through direct mail to participants

Position papers summarizing the findings and analysis are presented to senior NYSDOH managers and its designee the IMT. Recommendations are prioritized by NYSDOH in consultation with the State Medicaid Director and State agency partners on the basis of the scope of the policy, its impact on waiver participants, and the overall ability of the State to accommodate any fiscal impact.

Subsequent recommendations are approved in keeping with programmatic priorities, consumer benefit, and the opportunity for administrative efficiency and system wide reform.

If the system change is accepted but cannot be made administratively, certain measures are recommended and

implemented though the established annual NYS budget and legislative process. At this stage, NYSDOH staff, in collaboration with other state agency partners, brief NYS Division of the Budget and Legislative staff, and discuss the proposals with program participants, advocates, providers, and other stakeholders to gain their input and support.

NYSDOH staff and its designee, the IMT, implement system change when authorized by NYSDOH and the Medicaid Director. . All MCOs must comply with the provisions in their contracts regarding Quality Assurance and reporting to the state. Each MCO may be required, at the State's option, to conduct an internal performance improvement project (PIP) on a topic affecting the children's populations. Each MCO will separately track, trend, and report complaints, grievances, appeals, and denials related to the children's populations and services including HCBS. For children eligible for HCBS, each MCO's UM BH subcommittee shall separately report, monitor findings and recommend appropriate action on the following additional metrics:

i. Use of crisis diversion and crisis intervention services;
ii. Prior authorization/denial and notices of action;
iii. HCBS utilization;
iv. HCBS quality assurance performance measures as determined by the State and pending CMS requirements; and
v. Enrollment in Health Home.

The types of quality improvement reports that are compiled include the following
-Tracked and trended aggregated data and review data including all HCBS performance measures,
Data and information on all delineated performance measures to ensure compliance with state and federal regulations and to identify patterns, trends, and concerns/issues,
-Monitoring of any corrective action plans associated with the administration of the Children's waiver,
-Provider designation issues, and
-Quality assurance/quality improvement initiatives and activities.

The frequency with which such reports are compiled: Reports are compiled as specified in the HCBS Assurance measure or on a quarterly basis if not otherwise specified
Results are communicated, and with what frequency, to agencies, waiver providers, participants, families and other interested parties, and the public:
• The IMT at quarterly meetings.
• The MCOs or HHs to discuss any identified issues or concerns using regularly scheduled monthly and quarterly meetings and established contractual communication channels.
• Participants, families and other interested parties and the public – through the State's web-site, regularly scheduled quarterly and annual meetings with advocates, and through direct mail to participants.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: HH	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Oversight of the concurrent waivers is performed by an Interagency Monitoring Team (IMT), chaired by NYSDOH staff, with representation from State children's licensure, certification, designation and service agencies. An interagency agreement outlines oversight roles of IMT partners. NYSDOH, through the IMT committee holds the primary responsibility for monitoring and assessing the effectiveness of system and programmatic design changes to determine if the desired effect has been achieved. This includes incorporation of feedback from participants, stakeholders, providers, MCOs and Health Homes. At IMT meetings, which occur at least quarterly, IMT members:
-Track and trend aggregated data and review data including all HCBS performance measures
-Present and analyze data and information on all delineated performance measures to ensure compliance with state and federal regulations and to identify patterns, trends, and concerns/issues,
-Provide oversight and monitoring of any corrective action plans associated with the administration of the Children's waiver, and
-Develop, oversee, and monitor quality assurance/quality improvement initiatives and activities. NYSDOH and the IMT meets with the MCOs or HHs to discuss any identified issues or concerns.

NYSDOH contracts with an EQRO, as required by federal managed care regulations, to evaluate the MCOs' compliance with the quality assurance standards outlined in the contract. Representatives of the IMT, in conjunction with the External Quality Review Organization (EQRO), also conduct an annual review of each MCO's operations. A written report of findings is generated and a plan of correction for deficiencies is implemented if needed annually.

For FFS specifically, the State collects, monitors, and analyzes feedback regarding system design changes using several different methods. The participant survey method is used to gauge the effectiveness of the waiver program by asking for the input of those who use the waiver's services. The HHCM and NYSDOH with the IMT staff record and gather responses to system changes in the waiver by contacting and meeting with parents, advocate groups, providers and other stakeholders.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The quality improvement (QA/QI) strategies are reevaluated on an annual basis and whenever areas of improvement are identified. Post assessments of QA/QI initiatives are used to determine the effectiveness of the QA/QI initiatives and whether these new activities should become an ongoing part of the program and/or whether additional strategies are needed. The Quality Assurance Reporting Requirements (QARR) results are posted on the DOH website.

The IMT reviews the Quality Improvement Strategy QIS and its deliverables on at least an annual basis and will provide updates to CMS when appropriate. Evaluation of the QIS is the responsibility of the IMT and will take into account the following elements:
-Compliance with federal and state regulations and protocols
-Effectiveness of the strategy in improving care processes and outcomes
-Effectiveness of performance measures used for discovery
-Relevance of the strategy with current practices

Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID pandemic, a quality review report was not completed for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been submitted. Upon expiration of the Appendix K amendment, NYS-DOH will gather data and submit the quality review in addition to any outstanding 372 reports as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 report(s) within 90 days of receiving the final quality review report and 372 report acceptance decision.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Non-State Govt and Private non-profit/proprietary provider agencies provide HCBS. Non-profit organizations include not-for profit corporations formed under the NYS Law or authorized to do business in NY. DOH is the NY single State agency monitoring payments made under the Medicaid program. The Office of the State Comptroller (OSC), the Office of the Attorney General (AG), the Department of Health, and the Office of the Medicaid Inspector General (OMIG) conduct Statewide audits of Medicaid. Local counties also conduct reviews and audits of Medicaid funded programs.

Annual Fiscal Reporting: FFS providers submit an annual fiscal report. Non-State FFS Providers are considered delinquent and subject to a rate penalty if they have not filed a complete and compliant annual fiscal report by the due date after the end of the provider's fiscal reporting period.

Oversight of Service Delivery and Billings and Claims: Each waiver year, DOH conducts case reviews using a quality assurance review pool that includes all waiver service providers with waiver service billings. Paid claims will be reviewed to ensure that providers are appropriately billing for authorized services, correct reimbursement rates/fees, and for the correct number of units of service. DOH conducts an annual review of less than 100% of records of individuals actively enrolled in Children's Waiver services at the time of the review using a statistically reliable sample with a 95% confidence interval and a 5% margin of error using Raosoft formulas. The DOH sample crosswalks paid claims data to Care Plans to ensure that billing is consistent with services in the approved plan. Audit protocols are applied to a specific provider type or category of service through the audit. Audit protocols are used to evaluate a provider's compliance with Medicaid requirements and to determine the propriety of Medicaid expended funds. All waiver providers are subject to audits. Any systemic deficiencies will have a plan of correction developed which may result: new directives to providers, procedural remedy, specific vendor intervention (vendor hold and/or termination), or amendment to the waiver application. Improperly paid claims will be recouped by the state and FFP returned to CMS. Annual DOH quality assurance reviews completed within 12 months following the end of the waiver year.

OMIG(Office of the Medicaid Inspector General) annually audits FFS Medicaid providers. OMIG uses audit protocols to evaluate compliance and to determine the propriety of Medicaid expended funds. All waiver providers are subject to audits and DOH quality assurance reviews.

The HHCM (Health Home Care Manager) and MCOCC (Managed Care Organization Care Coordinator) contact the participant to assess if services are being provided. Discrepancies between the POC and delivered services are identified through a range of methods including retrospective reviews of the POC and paid claims, provider surveillance, and/or information received by the HHCM, MCO and/or DOH staff.

Random review of cases compares paid claims to authorized POC services with families certifying that waiver services were provided in accordance with the POC. Every waiver participant must have a recipient restriction/exception (R/E) code on his or her Medicaid enrollment file that identifies the child as a Children's waiver participant. The eligibility worker is responsible for putting the Children's R/E code and effective date on the participant's WMS file.

Under managed care, the MCO is non-risk for at least the first year of the waiver and will be at risk for HCBS after year 2 at the earliest or no earlier than 4/1/2023. The MCO post-payment review process is described in Appendix I-2-d where MCOs validate that waiver services were provided as billed through regular record reviews. The review results are included in the MCO's fraud and abuse prevention and detection plan consistent with 42 CFR 438.608(a)(1)(vii) and (5). This includes determining the accuracy of documentation, eligibility, services provided, and units billed.

MCOs conduct post-payment reviews and report annually in the fraud and abuse detection prevention plan including sending EOBs for enrollees to review; training staff to respond to inquiries regarding suspect EOBs; "secret shopper" programs; data mining with predictive analytics software and statistical modeling to identify patterns of fraudulent billing; "red flagging" providers with identified suspect activity; internal audits and internal controls for claims adjudication; investigation of internal and external referrals of potential fraud or abuse; quarterly and annual trend reports; and on-site review of medical charts to confirm billed services. The MCO verifies actual service delivery against the EOB (claims processed) consistent with HCBS assurance PMs in Section D of this waiver. For children in managed care, Division of Health Plan Contracting and Oversight (DHPCO) staff meet monthly with the MCOs' administrators allowing for the review of financial reporting and budget items, as needed.

Disclosure of Financial Records and Processes: The MCO maintains an accounting system consistent with generally accepted accounting principles (GAAP). The MCO and any subcontractors shall make available to the State, its agents, and appropriate federal representatives, any financial records of the MCO or subcontractors. Accounting procedures, policies and records are completely open to State and federal audit during the Contract Period and for six years thereafter.

Single Audit Act/Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (UAR): The 1915(c) operates concurrently with the 1115 waiver in the Mainstream Medicaid managed care program. DOH ensures the integrity of payments to MCOs through contract provisions consistent with federal regulations. Payments to MCOs are subject to ongoing fiscal accountability monitoring and reporting requirements to CMS, consistent with the 1115 Special Terms and Conditions. Under managed care, the state makes PMPM payments to the MCOs. The MCOs in turn pay individual providers, who are part of their networks, and are subject to contracting protections/reviews/member safeguards. The activities include comprehensive utilization management, quality data reporting and monitoring, and a compliance officer dedicated to the MMMC program, with a compliance committee that has access to MCO senior management. As activities are, the MCOs provides regular and ad hoc reporting of results. DOH has oversight of the program and MCO contracts, including financial integrity and corporate compliance/program integrity. Interagency monitoring, an important part of the overall state's Quality Improvement Strategy, provides quality review and monitoring and includes program management, contract management, and financial management staff from DOH.

DOH to ensures financial accountability ensuring payments are only made to an MCO for eligible persons who have been properly enrolled in the waiver and through the External Quality Review process. The eMedNY system only pays for Medicaid eligible children according to the rate schedule certified by the State's actuary and approved by CMS.

Independent Audits: NY secures an independent audit through an independent CPA as part of the Single Audit Act. MCOs, who manage the 1915(c) waiver services, must contract with and submit an annual independent audit of its internal controls and other financial and performance systems by an external company to ensure financial and operational viability and to ensure contract compliance as a condition of the Medicaid provider agreement. The independent audit must comply with the Statement on Standards for Attestation Engagements (SSAE) SSAE No. 16 SOC 2 Type II requirements. The audit period must be 12 consecutive months with no breaks between subsequent audit periods. The MCO must submit copies of all certified financial statements and QARR validation audits by auditors independent of the Contractor to the SDOH within thirty (30) days of receipt by the Contractor. Annual statements are due April 1 following the report closing date. Quarterly Financial Statements and Staffing Data A) The MCOs submit Quarterly Financial Statements to SDOH. Quarterly reports are due forty-five (45) days after the end of the calendar quarter. DHPCO receives a copy of the annual audit. DHPCO staff asks the MCO for additional information on material issues. When a CPA does an audit, the CPA must determine if the entity is financially viable for the next fiscal year. If the CPA determines the entity is not financially viable, then the CPA must issue an ongoing concern opinion. Non-MCO NY providers are not required to secure an independent audit of their financial statements; however, full consolidated fiscal reports must be certified by an independent certified public accountant. This certification is affirmed on either Schedule CFR-ii or Schedule CFR-iiA. Please note the CFR manual has exceptions to having a Full CFR certified if alternative certification or criteria are met. Health Homes under 1945 of the Social Security Act qualified to provide HCBS must meet Medicaid State Plan requirements for Health Homes and are not subject to the CFR process.

Other Financial Reports: The MCOs submit financial reports, including certified annual financial statements, and made available documents relevant to its financial condition to SDOH and the State Insurance Department (SID) in a timely manner as required by State laws and regulations, including but not limited to PHL §§ 4403-a, 4404 and 4409, Title 10 NYCRR Part 98; and when applicable, SIL §§ 304, 305, 306, and 310. The SDOH may require the Contractor to submit such relevant financial reports and documents related to its financial condition. For children in managed care, Division of Health Plan Contracting and Oversight (DHPCO) staff meet monthly with the MCOs' administrators allowing for the review of financial reporting and budget items, as needed. DHPCO will receive a copy of the annual audit. If there are any material issues, DHPCO staff will ask the MCO to provide additional information. When a CPA does an audit, one of the items they are required to do is determine if the entity is financially viable for the next fiscal year. If they determine that they are not financially viable, then they are required to issue an ongoing concern opinion.

Independent Audit:
Independent Audits: The MCO must submit copies of all certified financial statements and QARR validation audits by auditors independent of the Contractor to the SDOH within thirty (30) days of receipt by the Contractor. The MCO is required to secure an independent financial audit. This is a condition of the Medicaid provider agreement. The State of New York is required to secure an independent audit through an independent CPA as part of the Single Audit Act.

The MCOs submit Annual Financial Statements to SDOH. The due date for annual statements shall be April 1 following the report closing date. Quarterly Financial Statements and Staffing Data A) The MCOs submit Quarterly Financial Statements to SDOH. The due date for quarterly reports shall be forty-five (45) days after the end of the calendar quarter. Other Financial Reports: The MCOs submit financial reports, including certified annual financial statements, and made available documents relevant to its financial condition to SDOH and the State Insurance Department (SID) in a timely manner as required by State laws and regulations, including but not limited to PHL §§ 4403-a, 4404 and 4409, Title 10 NYCRR Part

98; and when applicable, SIL §§ 304, 305, 306, and 310. The SDOH may require the Contractor to submit such relevant financial reports and documents related to its financial condition.
Continued on Main B

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of FFS claims paid using FFS rates that follow the rate methodology in the approved waiver application (N Number of FFS claims paid using FFS rates that follow the rate methodology in the approved waiver application / D All FFS claims paid)

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
HCBS FFS Rate Schedule Records; FFS Claim Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*

☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *State Medicaid Agency designee (NYSTEC)*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
 # and % of waiver claims paid only for services rendered when part were enrolled in the waiver and eligible for such services, and when the services were provided by a qualified provider(N # of waiver claims paid only for services rendered when part were enrolled in the waiver and eligible for such services, and when the services were provided by a

qualified provider/D Total claims paid)

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
State HCBS provider designation files; FFS Claim & MC Encounter Data; Participant Enrollment Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *State Medicaid Agency designee (NYSTEC)*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
 # and % of MC Children's Waiver payments for claims coded & paid for in accordance with the reimbursement methodology specified in the approved waiver & only for services rendered(N # of MC Children's Waiver payments for claims coded & paid for in accordance with the reimbursement methodology specified in the approved waiver & only for services rendered/D Total MC Children's Waiver payments paid)

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MC Encounter Data; MC Rate Methodology

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *State Medicaid Agency designee (NYSTEC)*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
 # and % of providers with no payment(s) recouped because claims were coded and paid with the reimbursement methodology specified in the approved waiver and only for services rendered(N # of providers with no payment(s) recouped because claims were coded and paid with the reimbursement methodology specified in the approved waiver and only for services rendered/D Total providers reviewed)

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
OMIG Audit/Reviews

Responsible Party for data collection/generation	***Frequency of data collection/generation***	***Sampling Approach****(check each that applies):*

(check each that applies):	*(check each that applies):*	
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *90% Two-sided CI which is equal to 95% CI +/- 5% margin of error*
☒ ***Other*** *Specify:* *OMIG*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:*	☒ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
State Medicaid Agency designee (NYSTEC) and OMIG	
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of claims verified through an OMIG audit to have paid in accordance with the participant's waiver POC (N Number of claims verified through an OMIG audit to have paid in accordance with the participant's waiver POC / D Total claims audited)

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
OMIG audits

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *90% two sided CI, which equals 95% CI with +/- 5% margin of error*
☒ ***Other*** *Specify:* *OMIG*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *State Medicaid Agency designee (NYSTEC) and OMIG*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of FFS claims and MC encounters paid in accordance with the waiver's approved rates and methodologies. (N Number of FFS claims and MC

encounters paid in accordance with the waiver's approved rates and methodologies / D Total number of FFS claims and MC encounters paid)

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
FFS Claim & MC Encounter Data; FFS & MC Rate Methodologies

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *State Medicaid Agency Designee (NYSTEC)*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

The remediation process is initiated when the MCO or NYSDOH waiver management staff identifies a lack in the quality of provided services, or any other significant issue related to administration of the Children's waiver.

Remediation of financial issues begins immediately upon the discovery of any impropriety. NYSDOH waiver management staff, and other Department staff such as staff within the Fiscal Management Group (FMG), Provider enrollment and others, MCO as appropriate, immediately initiate remediation of any inappropriate claims processed through eMedNY or through the MCO. Remediation may include voiding payments, adjusting paid claims, assigning penalties, and sanctioning providers through collaboration with OMIG and the Attorney General.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide Children's waiver services. In such circumstances, NYSDOH waiver management staff will issue a letter to the provider terminating the provider's Children's waiver provider status.

Prior to 3/1/2024, the Governmental Entity (for FFS enrollees) or the MCO (for managed care enrollees) secures a local contractor and/or evaluator qualified to complete the required work. In the case of vehicle modifications, the evaluators and modifiers are approved by the NYS Education Department's Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES- VR). Activities include and are not limited to determining the need for the service, the safety of the proposed modification, its expected benefit to the child, and the most cost effective approach to fulfill the child's need. Standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that contractors are qualified and that State required bidding procedures have been followed. For Environmental Modifications, the governmental entity or MCO is the provider of record for billing purposes. Services are only billed to Medicaid or the MCO once the contract work is verified as complete and the amount billed is equal to the contract value. Home modifications are limited to individual or family owned or controlled homes. For FFS children receiving Environmental Modifications, Vehicle Modifications and Adaptive and Assistive Technology Vendor, the Local Department of Social Services (LDSS) or DDRO claims these costs from the State. The Welfare Management System (WMS) is a mechanism for LDSS to report Medicaid expenditures to NYSDOH. These expenditures are authorized in WMS with a payment specific code and special

claiming category for federal participation. Additional codes designate federally nonparticipating expenses and Non-Reimbursable expenses. The Governmental Entity and NYSDOH monitor this data. NYSDOH will advise the Governmental Entity of any inappropriate claims and the Governmental Entity staff will initiate remediation of the incorrect claim(s.) An unsatisfactory Environmental or Vehicle Modification contractors will be notified that the contractor will be disqualified from further service by NYSDOH.

After 3/1/2024, the FMS secures a vendor qualified to complete the required work for Environmental or Vehicle Modifications, Adaptive and Assistive Technology, and/or Transitional Services (effective 1/1/2026) Vendors. Activities include and are not limited to determining the need for the service, the safety of the proposed technology, its expected benefit to the child, and the most cost effective approach to fulfill the child's need. Services are only billed to Medicaid once the Assistive and Adaptive Technology or Environmental and Vehicle Modification is verified as received and the amount billed is equal to the contract value. After 1/1/2026, this same applies to Transitional Services.

The FMS secures a contractor and/or evaluator qualified to complete the required work: Prior to 1/1/2026 for V-mods evaluators and modifications are approved by NYS Education Department Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR); After 1/1/2026 for V-mods the evaluators and modifiers are approved by the National Mobility Equipment Dealers Association (NMEDA). Activities include and are not limited to determining the need for the service, the safety of the proposed modification, its expected benefit to the child, and the most cost effective approach to fulfill the child's need.

For Environmental Modifications, the FMS is the provider of record for billing purposes. Services are only billed to Medicaid once the contract work is verified as complete and the amount billed is equal to the contract value. Home modifications are limited to individual or family owned or controlled homes. The FMS monitor this data. NYSDOH will advise the FMS of any inappropriate claims and the FMS staff will initiate remediation of the incorrect claim(s.)

The FMS responsible for providing FMS services will identify unsatisfactory vehicle modification, home modification, transitional service and adaptive and assistive technology contractors. The FMS will disqualify unsatisfactory contractors and will find alternate contractors when necessary. Unsatisfactory accessibility modification, transitional service, and adaptive and assistive technology contractors will be notified of their disqualification from further service by the administering MCO, FMS, or DDRO and LDSS (through the transition).

Documentation of remediation activities is accomplished by the following measures: correspondence among NYSDOH waiver management staff, MCO staff, the HHCM, participants' and their parents/legal guardians, and/or service providers; amended plans of care; case reviews and reports of follow-up meetings with participants and their families; and the results of NYSDOH and MCO annual reviews. All such documents are maintained in the participant's case file.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *State Medicaid Agency Designee (NYSTEC) and OMIG*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ◉ ***No***
- ○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The waiver will operate concurrently with the 1115 beginning October 1, 2019. This fee schedule expense reimbursement covers claims effective for dates of service beginning with the approval of the waiver.

Provider Reimbursement of Waiver Services: Children's HCBS are provided by Non-State Govt and Private provider agencies. Private provider agencies are non- profit organizations or proprietary agencies. Non-profit organizations include not-for profit corporations formed under the NYS Law or authorized to do business in NY. The New York State (NYS) Children's waiver transitioned into managed care concurrent with the 1115 authority on October 1, 2019. The HCBS services will be capitated no earlier than the second year of the waiver beginning 4/1/2023. As of 11/1/23, due to the PHE and subsequent labor shortage, the DOH and its actuaries have determined that NY's recent utilization experience does not provide sufficient data necessary to make credible actuarial adjustments carving Children's HCBS into the MCO monthly capitated rates. Effective with the 3/1/2024 amendment, HCBS will tentatively be included in capitation under the Managed Care capitation on 7/1/24. The fiscal report will be submitted to CMS within 16 months after the close of the reporting period.

The State's 4/1/2021 HCBS provider fee schedule is found at:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2021-04-01_bh_kids_hcbs_rate_summary.pdf

After 1/1/2026 the State's HCBS provider fee schedule is found at:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/hcbs_rate_summary.pdf

All Waiver rates are posted on the DOH website at:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/manuals.htm

I. Definitions Applicable to this Section

a. Consolidated Fiscal Report: The Fiscal Report is the report and associated instructions utilized by all government and non-government providers to communicate annual costs incurred as a result of operating the Children's waiver programs and services, along with related patient utilization and staffing statistics.

b. Rate: a fee established for reimbursement of each unit of service provided.

c. The waiver services and units of Service: The unit of measure varies by the type of service, i.e., 15 min., per episode, per project. The waiver service unit of measure are:

Community Habilitation per 15m
Day Habilitation per 15m end dated 1/1/2026
Caregiver/Family Advocacy and Support Service (individual, group of 2, group of 3) per 15m
Pre-Vocational Services (individual, group of 2, group of 3) per 15m
Supported Employment per 15m
Palliative Care Pain and Symptom Management per hour
Palliative Care Counseling and Support Service per hour, per episode (2 per episode units) (Counseling and End of Life Duties are separate per episode fees)
Palliative Care Massage Therapy per hour
Palliative Care Expressive Therapy per hour
Respite Planned (individual, group of 2 and group of 3 - up to 6 hours per 15m)
Respite Planned (individual – 6-12 hours, 12-24 hours) per diem
Respite Crisis (up to 6 hours) per 15m
Respite Crisis (6-12 hours and 12-24 hours) per diem
Habilitation (individual, group of 2 or group of 3) per 15m
Non-Medical Transportation-per trip
FMS-Per project
Transitional Care Coordination per month

II. Reporting Requirements

a. The State Government Providers, Non-State Government Providers and Private Providers shall identify provider costs

in accordance with Generally Accepted Accounting Principles (GAAP.)

b. The State's required Consolidated Fiscal Reporting forms are completed annually
Consolidated Fiscal Reporting for non-profit waiver services will be subject to review. The Consolidated Fiscal Report will be submitted to CMS within 16 months after the close of the reporting period. The Children's waiver does not include state providers.

III. Services Paid via Fee Schedule: Statewide Rates for All providers includes:

Caregiver/Family Advocacy and Support Service
Pre-Vocational Services
Supported Employment
Palliative Care Pain and Symptom Management
Palliative Care Counseling and Support Service
Palliative Care Massage Therapy
Palliative Care Expressive Therapy
Respite Planned
Respite Crisis
Community Habilitation
Day habilitation end dated 1/1/2026
FMS
Transitional Care Coordination

For the 4/1/22 renewal: Fees are based on historical provider costs adjusted for trend. Additionally, fees established for the first 6 months of waiver year 1 have been set at an increase of 25% over historical reimbursements to assist providers to build capacity to meet the increasing need as per New York's CMS Approved 9817 spending plan. For Waiver Year 1, New York uses an increase on price of 20% which is a blend of 25% for half the year (ARPA 9817 rate update, since those rate updates weren't in the system when the base data was pulled) and a PROJECTED 15% for Rate Rebasing to remain in effect after October in the first year. The second year the price trend is reduced by 5%, to bring the price down from a 20% increase to 15% PROJECTED as the rebased rates continue. In Subsequent years, NY projected services with the 6.8% Price trend from CPI as the waiver included trend language.

Effective 11/1/23, rates are permanently amended to continue the 25% rate increase awarded under New York's Spending Plan under Section 9817 of the American Rescue Plan Act and the 5.4% cost of living adjustment, both of which were authorized under Appendix K during the COVID-19 Public Health Emergency. In Subsequent years, NY projected services with the 6.8% Price trend from CPI as the waiver included trend language. New York allows for annual COLA increases to rates, subject to state budget requirements and legislative approval.

Effective 1/1/2026, E-Mod, V-Mod, and AAT FMS are increased based on data assumptions provided by the FMS entity, data assumptions used in the Health Home Serving Children (HHSC) 1/1/2024 rebase, and utilization from the 2020/21 372 data. In Subsequent years, NY projected services with the 6.8% Price trend from CPI as the waiver included trend language.

Transitional Service (TS) FMS and Transitional Care Coordination (TCC) services are being newly added as waiver services with this amendment. The TS FMS rate was set utilizing the same data assumptions as AAT. TCC rates were set based on data assumptions used in the HHSC 1/1/2024 rebase, and utilization based on inpatient/nursing utilization and length of stay data as well as workgroup meetings and discussion with institutions regarding children who could potentially discharge with supportive services. In Subsequent years, NY projected services with the 6.8% Price trend from CPI as the waiver included trend language.

New York allows for annual COLA/TII increases to rates, subject to state budget requirements and legislative approval.

All fees are for an individual setting and a 15-minute unit of service unless otherwise indicated. Group rates are individual rates adjusted for expected group size. Per diems for extended periods of time were developed separately from associated individual rates and may vary for different lengths of time.

Geographical rate variations for all of the above services are included to reflect wage and resource cost differences

between upstate, downstate and rural regions. Effective 11/1/23 a new regional geographic rate variation is being added for designated rural regions. NY developed upstate, downstate and rural rates for all rates because of specific variations in wages and resource costs affecting the service delivery. For Adaptive and Assistive Technology, Vehicle Modifications, Environmental Modifications, and Transitional Services the vendor will bill the actual amount of the technology or modification.

Non-Medical Transportation-per trip rate: fees will be established and approved by the NYSDOH Office of Health Insurance Programs. Fees will be reviewed to ensure they do not exceed the current usual and customary amount charged to the general public.

IV. Services paid using a Contract Amount

a. Environmental Modifications, Vehicle Modifications, Transitional Services or Adaptive and Assistive Technology.

i. Prior to 3/1/2024, the governmental entity/Health Home/MCO is the provider of record for Environmental Modifications, Vehicle Modifications, or Adaptive and Assistive Technology for billing purposes. The work is done by a contractor who is selected by the governmental entity using a standard bidding process, following the state rules or Health Home (for FFS) or the MCO process (for managed care). Environmental Modifications or Vehicle Modifications are only billed to Medicaid or the MCO once the contract work is verified as complete and the amount billed is equal to the contract value. Environmental modifications are limited to individual or family owned or controlled homes.

After 3/1/2024, the FMS will be the provider of record for new Environmental Modifications, Vehicle Modifications, and Adaptive and Assisted Technology. Projects are only billed to Medicaid once the contract work is verified as complete and the amount billed is equal to contract value. Environmental Modifications are limited to individual or family owned or controlled homes.

After 1/1/2026, the FMS will be the provider of record for new Environmental Modifications (E-Mods), Vehicle Modifications (V-Mods), Adaptive and Assisted Technology (AAT), and Transitional Services (TS). Projects are only billed to Medicaid once the contract work is verified as complete and the amount billed is equal to contract value. E-Mods are limited to individual or family owned or controlled homes.

ii. The maximum expenditure for Environmental Modifications or Vehicle Modifications for the benefit of the individual Medicaid beneficiary may not exceed $25,000 per year for environmental modifications, $35,000 per year for safe passenger, and $65,000 per five years for driver vehicle modifications. If the person requires an expenditure which exceeds the maximum expenditure amount the Medicaid agency may grant exceptions with medical necessity documentation as outlined in the E-Mod or Safe passenger V-Mod service definition, if applicable. After 3/1/2024, the FMS in conjunction with DOH may grant these exceptions.

iii. The maximum expenditure for Transitional Services for the benefit of the individual Medicaid beneficiary may not exceed $8,000 per year. If the person requires an expenditure which exceeds the maximum expenditure amount the Medicaid agency may grant exceptions with medical necessity documentation.

After 3/1/2024, the FMS in conjunction with DOH may grant these exceptions.

V. Trend Factors

The trend factor applied will be the applicable years from the Medical Care Services Index for the period April to April of each year from www.bls.gov/cpi; Table 1 Consumer Price Index for All Urban Consumers (CPI-U); U.S. city average, by expenditure category and commodity and service group. The consolidated children's waiver rates may be trended from time to time, at the discretion of DOH and only with the approval of CMS. When trended, the trend used will be based on the CPI-U Medical Services for all Urban Consumers, as published by the BLS, over the period of the trend and extrapolated as needed. If parents/guardians of participants have any questions about the payment rates made to the Children's waiver providers, they may contact their care manager or the DOH Public Affairs Office to obtain this information.

NYSDOH is responsible for HCBS rate determination in all years of the waiver. NYSDOH is responsible for capitation rate determination for MCO rates that include HCBS no earlier than year two of the waiver.

Continued in Main B

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

For FFS, billings flow directly from the provider to New York State's MMIS (eMedNY).

1)The following services are reimbursed through a fee rate schedule that has upstate and downstate rates:
•Community Habilitation
•Day Habilitation end dated 1/1/2026
•Caregiver/Family Advocacy and Support Service
•Respite
•Prevocational Services
•Supported Employment
•Non-Medical Transportation
•Palliative Care Expressive Therapy
•Palliative Care Massage Therapy
•Palliative Care Counseling and Support Service
•Palliative Care Pain and Symptom Management
•FMS - starting 3/1/2024
•Transitional Care Coordination – starting 1/1/2026

Prior to 11/1/2023, Environmental Modifications, Vehicle Modifications, and Adaptive and Assistive Technology will utilize the governmental entity or MCO as the provider of record. If the governmental entity is the provider of record, NYS utilizes a vendor bid process for home and vehicle modifications; and payments are made to the provider by the Governmental Entity. If the MCOs is the provider of record, the MCO will secure a local vendor qualified to complete the required work for Environmental Modifications, Vehicle Modifications, or Adaptive and Assistive Technology Vendors using its own procurement/contracting processes. Services are only billed to the MCO once the technology/modification is verified as received and the amount billed is equal to the contract for the services paid.

Effective 11/1/2023, any new Environmental Modifications, Vehicle Modifications, and Adaptive and Assistive Technology will be processed by the FMS using the FFS delivery system.

Effective 3/1/2024, the FMS will be the provider of record for any new Environmental Modifications, Vehicle Modifications, and Adaptive and Assistive Technology under the FFS delivery system.

Effective 1/1/2026, the FMS will be the provider of record for any Environmental Modifications, Vehicle Modifications, Transitional Services, and Adaptive and Assistive Technology under the FFS delivery system.

For all HCBS through the MCO, billings flow directly from the provider to the MCO. Capitation payments for HCBS will not begin until at least waiver year two. The MCO receives a capitated payment from the NYSDOH MMIS eMedNY. Billings flow directly from the provider to the MCO. The MCO receives a non-risk payment after invoicing the NYSDOH MMIS eMedNY for the services paid. No earlier than waiver year two 4/1/2023, the MCO receives a capitated payment from the NYSDOH MMIS eMedNY. The MCO billings to the state are made in accordance with the provisions of the 1115 waiver and provider billings to the MCO are made in the terms of the provider's contract with the MCO.
No sooner than waiver year 2 4/1/2023, the MCO receives a capitated payment from the NYSDOH MMIS eMedNY.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

◉ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

For both FFS and managed care, an OMIG audit will verify that claims are paid in accordance with the participant's waiver POC using a sampling methodology with a two sided 90% confidence interval equaling a 95% one sided confidence interval with a margin of error of +/- 5% and reported on an annual basis to DOH.
Fee-for-service
Claims for all HCBS waiver services are adjudicated by eMedNY. The eMedNY system identifies HCBS enrollees with codes (Restriction/Exemption/RE) that identify the person as HCBS enrolled and the effective date of the enrollment. Payment system edits require the client record to indicate active Medicaid eligibility and HCBS Waiver enrollment for all dates of service billed. All FFS billings are processed either through eMedNY or through direct payment to the vendor by the FMS for E-Mods/V-Mods/TS or AAT and will be subjected to eligibility and payment edits. All managed care billings are processed through the MCO which is subject to the External Quality Review process.
For waiver services adjudicated through eMedNY, Children's participants' eligibility for the waiver services on the date of the claim is verified through the payment system edits.

Prior to the final payment for Environmental Modifications or Vehicle Modifications, the FMS staff, the contractor or/and care manager verifies the completion by assuming a signed statement of satisfactory completion by the parent/legal guardian of the beneficiary. A copy of the statement is maintained as part of the case.

If an overpayment is discovered, the provider is requested to repay the state via check or withholding of payments. OMIG submits a weekly action report to DOH requesting specific transactions be made in relation to each active OMIG Account Receivable (A/R). These transactions include but are not limited to, establishing an A/R, withholding provider payments from prospective MA billings, refunding underpayments, and suspending MA payments. OMIG Collections compiles information from DOH and OMIG activities to receive and reconcile receipts against OMIG A/Rs. Currently, this process is limited to FFS transactions.

Managed Care
When an individual has been determined to be eligible for the waiver, the HHCM sends notification to NYSDOH or its designee through the HCS system.

A POC is developed for all participants served through the waiver. All waiver services on the plan of care are authorized by the MCO. Communication between the HH and the MCO will occur to ensure that the plan of care is received, reviewed, and approvals are processed in a timely manner as detailed below.

When a waiver service claim is submitted to the MCO, the MCO's system electronically checks the plan of care and the eligibility roster to ensure the child/youth is waiver eligible for the dates of services included on the claim. In addition, the MCO's system electronically checks the provider file to assure the provider is enrolled with the MCO and is approved to receive Medicaid waiver payment for the date of services.

The MCO conducts post pay reviews to validate waiver services were in fact provided as billed. This financial integrity review is included in the MCO's fraud and abuse prevention and detection plan in compliance with managed care regulations at 42 CFR 438 Subpart H including requirements at 438.608(a)(1)(vii) and (5). This includes determining the accuracy of documentation, eligibility, services provided, and units billed. The MCOs sample members and report on a quarterly basis to verify actual service delivery against the EOB (claims processed).

Providers provide services consistent with the approved POC, maintain documentation and submit claims for services rendered.

MCOs conduct post-payment reviews and report annually in the fraud and abuse detection prevention plan including sending EOBs for enrollees to review; training staff to respond to inquiries regarding suspect EOBs; "secret shopper" programs; data mining with predictive analytics software and statistical modeling to identify patterns of fraudulent billing; "red flagging" providers with identified suspect activity; internal audits and internal controls for claims adjudication; investigation of internal and external referrals of potential fraud or abuse; quarterly and annual trend reports; and on-site review of medical charts to confirm billed services.

The State's MCO post payment review process includes on-site record review audits of MCO network providers to validate the Medicaid payments and determine if appropriate documentation is maintained to support the claims. The audits generally include a sample of 100 claims drawn from the claim universe, which are then extrapolated using a 90% two-sided confidence levels and may be stratified. OMIG conducts rolling audits utilizing data analysis or allegation

reviews to develop targets for audits and uses a 90% two-sided confidence interval.

State recoupment: Providers repay overpayment via check or withholding of payments. OMIG submits a weekly action report to DOH with transactions for each active OMIG Account Receivable (A/R). These transactions include establishing an A/R, withholding provider payments from prospective MA billings, refunding underpayments, and suspending MA payments. OMIG Collections compiles information from DOH and OMIG activities to receive and reconcile receipts against OMIG A/Rs. DOH uses the OMIG A/R to remove inappropriate billings from the claims for FFP on the CMS-64.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for HCBS in FFS are all made through the eMedNY. For Environmental modifications, Vehicle modifications, Transitional Services, and/or Adaptive and Assistive Technology, the FMS verifies the child's eligibility and makes a partial payment to the contractor at outset of the project. The FMS makes the final contract payment when it determines that the project has been completed as identified in the recipient's plan of care and receives the parent's signoff that the work has been completed satisfactorily. In addition, Environmental and Vehicle Modifications are reviewed as part of the NYSDOH annual sample review of cases. The FMS will claim consistent with FMS policy guidance. Environmental and Vehicle Modifications are reviewed as part of the NYSDOH annual sample review of cases. No earlier than waiver year 2 4/1/2023, the MCO entity is paid a monthly capitation rate through the MMIS. As of 11/1/23, due to the PHE and subsequent labor shortage, the DOH and its actuaries have determined that NY's recent utilization experience does not provide sufficient data necessary to make credible actuarial adjustments carving Children's HCBS into the MCO monthly capitated rates. Effective with the 3/1/2024 amendment, HCBS will tentatively be included in capitation under the Managed Care capitation on 7/1/24.)

Payments for HCBS to managed care enrollees are through the MCO. HCBS is paid non-risk through the MCO per 42 CFR 447.361 subject to the non-risk UPL. No earlier than waiver year two, the managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS (eMedNY).

For Environmental Modifications, Vehicle Modifications, and Adaptive and Assistive Technology purchases initiated prior to 11/1/2023 and billed through MCOs, the payment method is as follows and includes the clarification in I-3-a. (218): The MCOs will secure a local vendor qualified to complete the required work for Environmental Modifications, Vehicle Modifications, and/or Adaptive and Assistive Technology Vendors using its own procurement/contracting processes. Activities include and are not limited to determining the need for the service, the safety of the proposed Environmental and Vehicle Modifications and Adaptive and Assistive technology, its expected benefit to the child, and the most cost effective approach to fulfill the child's need. Services are only billed to Medicaid or the MCO once the Environmental and Vehicle Modifications and Adaptive and Assistive technology is verified as received and the amount billed is equal to the contract value. After 11/1/2023, all Environmental Modifications, Vehicle Modifications, and Adaptive and Assistive Technology purchases initiated will be paid through the eMedNY in the FFS delivery system. After 3/1/2024, the FMS will be utilized for Environmental Modifications, Vehicle Modifications, and Adaptive and Assistive Technology in the FFS delivery system. After 1/1/2026, the FMS will be utilized for Environmental Modifications, Vehicle Modifications, Transitional Services, and Adaptive and Assistive Technology in the FFS delivery system.

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☒ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

The MCOs are responsible for reimbursing for HCBS to their members.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that

the state or local government providers furnish:

Prior to 03/01/2024 for Adaptive and Assistive Technology, Vehicle Modifications and Environmental Modifications - A governmental provider may be the provider of record for Adaptive and Assistive Technology, Vehicle Modifications or Environmental Modifications. The term provider of records indicates that a Governmental Entity may contract with another private entity for the provision of services. There are no State or local government providers approved to provide Adaptive and Assistive Technology, Vehicle Modifications or Environmental Modifications. After 03/01/2024, a FMS will be the provider of record for all newly initiated Adaptive and Assistive Technology, Vehicle Modifications and Environmental Modifications purchases. After 1/1/2026, an FMS will be the provider of record for all newly initiated Adaptive and Assistive Technology, Vehicle Modifications, Transitional Services, and Environmental Modifications purchases.

County mental health and substance use disorder agencies may choose to participate in the waiver. These entities can provide any waiver service, providing they meet the qualifications established in Appendix C of this application.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ○ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ◉ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

There are no reductions or returns to the state that result in a disparity between the amount claimed to CMS and the amounts actually paid to the MCO. However, please note, that not all providers will be paid by an MCO. Only providers providing services to children in the managed care delivery system no earlier than waiver year two 4/1/2023 will be paid by an MCO under capitation. There will be a portion of children under the Children's Waiver (approximately 50% of enrollees) who remain in FFS.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ○ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ◉ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

In FFS prior to 03/01/2024, Environmental modifications, Vehicle Modifications and Adaptive and Assistive Technology are the only HCBS for which payments are reassigned. Vendors are required to sign a Statement of Reassignment that they will only bill the Governmental Entity for the adaptation specified in the child's approved plan and accept the contracted amount as payment in full. Furthermore, the vendor acknowledges that the Governmental Entity will request MA reimbursement via Schedule E, on behalf of the vendor, and retain any reimbursement obtained for these services. This process is specified in state guidance. The reassignment of direct payment is voluntary, and the provider is free to cancel the arrangement under which case, the provider will not provide the service. After 03/01/2024, a FMS will be the provider of record for all newly initiated Adaptive and Assistive Technology, Vehicle Modifications and Environmental Modifications purchases. After 1/1/2026, an FMS will be the provider of record for all newly initiated Adaptive and Assistive Technology, Vehicle Modifications, Transitional Services, and Environmental Modifications purchases.

ii. Organized Health Care Delivery System. *Select one:*

- ○ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ◉ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

a) FMS are providers of Health Home care management under the State Plan and must comply with 1945 of the Social Security Act. Health Homes which furnish financial management services must successfully undergo a readiness review as part of the determination that such entities are qualified to furnish these services.
b) It is not anticipated that there will be other providers of record for AT/E-Mods/V-Mods/TS. When financial management services are furnished as a waiver service, the number of providers may not be limited without a 1915(b)(4). The concurrent 1915(b)(4) waiver will permit NYS to selectively contract with Health Homes to be the Organized Health Care Delivery System (OHCDS) provider of record for AT/E-Mods/V-Mods/TS for FFS members.
c) Members may select any vendor of AT/E-Mods/V-Mods/TS. AT/E-Mods/V-Mod/TS vendors may not enroll directly with eMedNY, the state's MMIS system. However, the FMS will reimburse the AT/E-Mod/V-Mod/TS vendors selected by the member ensuring free choice of providers.
d) Financial Management Service is a new service under the Children's HCBS waiver. The Health Homes will establish written agreements with AT/E-Mod/V-Mod/TS providers, if applicable. An agreement with a vendor is not required but there must be documentation to verify the purchase of the AT/E-Mod/V-Mod/TS. The AT/E-Mod/V-Mod/TS vendor must meet the standards specified in the waiver and the FMS will verify provider qualifications at the beginning of the purchase.
Under a written agreement between the Health Homes and the State Medicaid agency, Health Homes will bill and be reimbursed for the AT/E-Mod/V-Mod/TS services they are managing and will be responsible for payment to the AT/E-Mod/V-Mod/TS providers. Under the contract with Health Homes, the Health Homes are held to the same contractual requirements of ensuring provider qualifications of purchased services including AT/E-Mods/V-Mods/TS. Health Homes are monitored to ensure that they contract with providers meeting applicable requirements.
e) Financial accountability is assured because Health Homes are required to bill eMedNY only for the amount of the AT/E-Mods/V-Mods/TS under
the rate codes for each of those services and under a separate rate code for the Fiscal Management Service. FMS must comply with current and future policies, standards and procedures, regulations, and operational policies implemented by DOH and the Centers for Medicare and Medicaid Services (CMS) for Health Homes generally and specifically with respect to Health Homes designated to serve children and participate in related case reviews and other oversight processes conducted by DOH.

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ◉ ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please***

select this option.

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☒ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

For FFS services delivered by provider agencies and managed care payments, the source of funds for the State share is tax revenues appropriated to NYSDOH. When provider agencies bill eMedNY for payment, the Department of Health funds the non- federal share expenditures.

State tax revenues are the source of funds for the state share for HCBS Waiver services delivered by NYSDOH. State funded appropriations support the State Share of Children's waiver claims. The federal share of Children's waiver funds is drawn down based on State Share claims. Such claims are adjudicated through e-MedNY.

The Medicaid State share is also provided through appropriations in NYSDOH for funds (net of any federal share) received from drug rebates, audit recoveries and refunds, third party recoveries; assessments on nursing home and hospital gross revenue receipts; and Health Care Reform Act (HCRA) revenues.

The General Fund (state tax revenue supported) state share for Medicaid is also appropriated in the NYS Office of Mental Health (OMH), NYS Office for People With Developmental Disabilities (OPWDD), OCFS, NYS Office of Alcoholism and Substance Abuse Services, and NYS State Education Department budgets. Appropriations in OPWDD for the Mental Hygiene Patient Income Account and in OMH for HCRA also fund the State share of Medicaid and are transferred to NYSDOH. Funds are transferred from these agencies, upon approval from the NYS Division of Budget, to the NYS Department of Health (NYSDOH) using the certificate of approval process (funding control mechanism specified in the State Finance Law, or through journal transfers to NYSDOH).

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

○ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

◉ ***Applicable***

Check each that applies:

☒ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Counties in New York State and the City of New York have the authority to levy taxes and other revenues. These local entities may raise revenue in a variety of ways, including taxes, surcharges and user fees. The State, through a state/county agreement, has an established system by which local entities are notified at regular intervals of the local share of Medicaid expenditures for those individuals for which they are fiscally responsible. In turn, the local entities remit payment of these expenditures directly to the State.

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

  Check each that applies:

  - ☐ ***Health care-related taxes or fees***
  - ☐ ***Provider-related donations***
  - ☐ ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Room and Board costs, as defined by federal regulation, are included in only two (2) Children's waiver services, and then only for subsets of those services. They are: Planned and Crisis Respite Services that are provided in a qualifying residence or facility. Those two sub-sets have rate methodologies that include room and board costs, in accordance with 42 CFR 441.310(a) (2). Duplication of payments is prohibited.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to

the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Hospital, Nursing Facility, ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	3681.89	42002.27	45684.16	610725.85	55728.08	666453.93	620769.77
2	3994.09	44862.21	48856.30	652310.19	59522.60	711832.79	662976.49
3	4701.96	47916.88	52618.84	696726.01	63575.50	760301.51	707682.67
4	5303.78	51179.54	56483.32	744166.10	67904.36	812070.46	755587.14
5	6043.65	54664.35	60708.00	794836.40	72527.97	867364.37	806656.37

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care: Hospital	Level of Care: Nursing Facility	Level of Care: ICF/IID
Year 1	17379	12962	2835	1582
Year 2	17379	12962	2835	1582
Year 3	17379	12962	2835	1582
Year 4	17379	12962	2835	1582
Year 5	17379	12962	2835	1582

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Based on the 372 data, the actual average length of stay is 276.62 days. The value used in this application is the 276.62 from the 372 data. 4/1/2019 to 3/31/2020 was the date of the 372.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D values are estimated based on established payment rates of each waiver service, the number of units of service expected to be delivered annually, multiplied the number of participants expected to receive to each service.

The basis for these estimates is as follows: For year 1 of the waiver, D is calculated using the values from the 372 of the CMS-approved Children's waiver application, for the period 4/1/19-4/1/20. D rates were trended by the CPI for All Urban Consumers. D utilization was trended by 2.5% year over year.

The trend was developed using CPI for All Urban Consumers data through November 2021. A projected annual trend of 6.809% was developed by taking the November 2021 index (277.948) divided by the November 2020 index (260.229). Trending forward from November 2021 at 6.809% yielded an April 2022 index value of 285.8336.

For the 4/1/2022 renewal, the maximum expenditure of $25,000 per year reflects the average expected costs of Environmental and Vehicle Modifications. The State has updated the maximum expenditure of Environmental and Vehicle modifications in Section C Service Definitions because while the average amount of Environmental and Vehicle modifications are $11,024 and $14,336 respectively, bathroom, kitchen and vehicle modifications can routinely cost up to $25,000 each. In order to reduce the number of approvals and waivers required, New York is raising the maximum expenditure and the projection of costs. The Environmental and Vehicle Modifications Data is from the DRAFT 4/1/20-3/31/21 CMS 372.

For the 4/1/2022 renewal, the data source is the draft April 1, 2020 through March 31, 2021, 372 data for the Children's waiver and historic children's rates inflated by 25% as approved by CMS in the eFMAP initiative. CMS has approved a 25% rate increase for the Children's HCBS waiver under the eFMAP initiative. This was approved in Amendment NY.4125.R05.12. For Waiver Year 1, New York uses an increase on price of 20% which is a blend of 25% for half the year (ARPA 9817 rate update, since those rate updates weren't in the system when the base data was pulled) and a PROJECTED 15% for Rate Rebasing to remain in effect after October in the first year. The second year the price trend is reduced by 5%, to bring the price down from a 20% increase to 15% PROJECTED as the rebased rates continue. In Subsequent years, NY projected services with the 6.8% Price trend from CPI as the waiver included trend language. The 1915(c) Children's Waiver utilization from 4/1/2019 – 3/31/2021 was suppressed due to a lack of providers. The belief is that the recent 25% rate increases will help providers establish capacity and allow for more utilization in the future. Because these services and this capacity are new, we do not have data to draw on, but 2.5% growth per person and 10% growth in the first 2 years of the waiver and then 2.5% annual growth in the number of participants receiving services represents what we believe to be a reasonable estimate of utilization growth.

Effective 11/1/23, rates are permanently amended to continue the 25% rate increase awarded under New York's Spending Plan under Section 9817 of the American Rescue Plan Act and the 5.4% cost of living adjustment (Based upon NYS 2022-2023 approved budget), both of which were authorized under Appendix K during the COVID-19 Public Health Emergency. In Subsequent years, NY projected services with the 6.8% Price trend from CPI as the waiver included trend language. The trend from the renewal was developed using CPI for All Urban Consumers data through November 2021. A projected annual trend of 6.809% was developed by taking the November 2021 index (277.948) divided by the November 2020 index (260.229). Trending forward from November 2021 at 6.809% yielded an April 2022 index value of 285.8336. New York allows for annual COLA increases to rates, subject to state budget requirements and legislative approval.

Effective 1/1/2026, E-Mod, V-Mod, and AAT FMS rates are increased based on data assumptions provided by the FMS entity, data assumptions used in the Health Home Serving Children (HHSC) 1/1/2024 rebase, and utilization from the 2020/21 372 data. In Subsequent years, NY projected services with the 6.8% Price trend from CPI as the waiver included trend language.

Transitional Service (TS) FMS and Transitional Care Coordination (TCC) services are being newly added as waiver services with this amendment. The TS FMS rate was set utilizing the same data assumptions as AAT. TCC rates were set based on data assumptions used in the HHSC 1/1/2024 rebase, and utilization based on inpatient/nursing utilization and length of stay data as well as workgroup meetings and discussion with institutions regarding children who could potentially discharge with supportive services. In Subsequent years, NY projected services with the 6.8% Price trend from CPI as the waiver included trend language.

New York allows for annual COLA/TII increases to rates, subject to state budget requirements and legislative approval.

We believe that recent utilization per person has been suppressed due to a lack of providers and COVID. The belief is that the recent 25% rate increases will help providers establish capacity and allow for more utilization in the future. Because these services and this capacity are new, we do not have data to draw on, but 2.5% represents what we believe to be a reasonable estimate.

We believe that recent number of participants receiving services has been suppressed due to a lack of providers and COVID. The belief is that the recent 25% rate increases will help providers establish capacity and allow for more utilization in the future. Because these services and this capacity are new, we do not have data to draw on, but 10% in the first two years and 2.5% annually thereafter represents what we believe to be a reasonable estimate.

Public comment during the waiver period suggested that there are many children on the Children's waiver not receiving the services on their Plans of Care and instead waiting for services on wait lists due to low rates. New York has raised the reimbursement rates by 25% to incent providers to hire more staff and serve more children. The State anticipates that the number of children on the waiver receiving services has increased by 63% between 4/1/20 - 3/31/21 and 4/1/21 -3/31/22. This is based on preliminary data for the period. We are projecting a 10% increase between 4/1/21-3/31/22 and WY1 4/1/22 – 3/31/23 and then 2.5% annually, thereafter. This estimate approximates the number of children requiring more services, the number of providers willing to hire more practitioners, and the sensitivity of health care to price. Predicting the sensitivity of HCBS providers to price is not well documented in economic literature – consumer sensitivity is much more well documented. In October 2022, New York will revisit the rates and utilization to see if the supply meets demand and if additional changes are needed.

For the 11/1/2023 amendment, New York used the following data sources and base utilization with the same trend for the new services and rate restructuring:
-For the planned respite Group of 2 utilization New York used 50% of the planned respite group of 3 utilization, which was the historic planned group respite rate.
-The impacts of the rural rate are estimated to be less than $40,000 annually and are reflected as a .05% price increase starting in waiver year 2.

For the 3/1/2024 amendment
-The FMS was added to the waiver effective 3/1/2024.
-The number of capitated and non-capitated users and units for Adaptive and Assistive Technology, Environmental Modifications, and Vehicle Modifications were combined into the non-capitated component using the unique recipients from the originating draft April 1, 2020 through March 31, 2021 372 data for the Children's waiver, inflated as described above. Average units per users was calculated off of these figures for the respective waiver years.
-To determine the number of FMS users and units, for FMS sources and dates of service, New York used the sum of Adaptive and Assistive Technology, Environmental Modifications, and Vehicle Modifications users and units contained within the factor D estimates. Average units per users was calculated off of these figures for the respective waiver years.
-FMS is priced at $600 per modification and $500 per Adaptive and Assistive Technology project per the 1915(b)(4) waiver and weighted by the sum of managed care and FFS average units per user from the 372 data used in the renewal.
-Since the 4/1/22 renewal, DOH has utilized 4/1/20-3/31/21 CMS372 data as the basis for the creation of the Appendix J Factor D estimates. For the purposes of determining which recipients would be included as FFS vs. MC, DOH bifurcated the data based on whether the waiver recipients were enrolled in a MMC health plan for the period. Some recipients would have spent part of the base year in FFS, and part of that base year in MMC; and as a result, would be counted in both categories when disaggregated. When the DOH reaggregated the data to represent the implementation of the creation of FMS, we went back to the originating source data so as not to count the same recipients twice in the aggregated data. DOH believes this is the most accurate and faithful way to reflect the base data but is willing to change if CMS would prefer it to be represented differently.

For vehicle modifications, the overall limits have increased to $35,000 per year for safe passenger, and $65,000 per year for driver vehicle modifications, but the average costs are not anticipated to increase.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The basis for the D' was the draft CMS 372 Report for 4/1/2020 – 3/31/2021, which was $36,817.73. We trended it forward 2 year at 6.809% to find a WY1 value of $42002.27.

The trend was developed using CPI for All Urban Consumers data through November 2021. A projected annual trend of 6.809% was developed by taking the November 2021 index (277.948) divided by the November 2020 index (260.229). Trending forward from November 2021 at 6.809% yielded an April 2022 index value of 285.8336.

There are a combination of reasons for why G' is greater than D' because of the diversity of the Children's Waiver populations (e.g., hospital, ICF, and NF). One of the primary differences for the hospital LOC is that children in hospital settings are typically seen by physicians daily, whereas a child in HCBS is only seen every 1-3 months. Because the children were all in the hospital for at least 6 months, this adds up quickly.

Potential Physician Hospital Reimbursement
99223 – initial day $178
99233-subsequent dates (178 days) $176
99239- discharge day $112
Total Hospital $31,328

Potential Physician HCBS Reimbursement 99215 (3 visits) $177 Total HCBS $531

For Children who are nursing facility eligible and ICF eligible, there are services outside of those per diems that also contribute to the cost.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G values were estimated using NYS actual expenditure data for ICF, nursing home and hospital care of child Medicaid recipients of the same age who have comparable disabilities to Children's Waiver participants for dates of service during the 2019-2020 waiver year. This information is generated from the eMedNY, AFPP Data Mart Claims system. [See Appendix I-1 for description of the eMedNY system.]

The trend was developed using CPI for All Urban Consumers data through November 2021. A projected annual trend of 6.809% was developed by taking the November 2021 index (277.948) divided by the November 2020 index (260.229). Trending forward from November 2021 at 6.809% yielded an April 2022 index value of 285.8336.

We have updated the G and G' to reflect the actual expenditures for ICF, nursing home, and hospital care of child Medicaid recipients of the same age who have comparable disabilities to Children's Waiver participants. Specifically, we pulled children under age 21 with stays of 180 days annually in an institution across the populations and then de-duplicated, in case a child appeared in more than one list. This will gave us the total universe of children. We then pulled all claims for the children and separated them by institutional (G) vs non-institutional (G') claims.
Nursing Facility-Identified children with a nursing facility R/E code and where the start/end dates show the child enrolled more than 180 days (6 months) during the WY in question. Hospital - Identified children with at least one hospital claim and the total stay was more than 180 days (6 months). ICF - Identified children with at least one approved/paid ICF claim and where the total stay was more than 180 days (6 months).

We used the 20/21 APC, which is the draft CMS 372 values for that year. The value we included for WY1 is trended 2 years at an annual value of 6.809%.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' values were estimated by using NYS actual expenditure data for all non-institutional MA State Plan services for the same Medicaid recipient group as for Factor G for dates of service during the 2019-2020 waiver year. This information is generated from the eMedNY AFPP Data Mart Claims system.

The trend was developed using CPI for All Urban Consumers data through November 2021. A projected annual trend of 6.809% was developed by taking the November 2021 index (277.948) divided by the November 2020 index (260.229). Trending forward from November 2021 at 6.809% yielded an April 2022 index value of 285.8336.

We have updated the G and G' to reflect the actual expenditures for ICF, nursing home, and hospital care of child Medicaid recipients of the same age who have comparable disabilities to Children's Waiver participants. Specifically, we pulled children under age 21 with stays of 180 days annually in an institution across the populations and then de-duplicated, in case a child appeared in more than one list. This will gave us the total universe of children. We then pulled all claims for the children and separated them by institutional (G) vs non-institutional (G') claims.
Nursing Facility-Identified children with a nursing facility R/E code and where the start/end dates show the child enrolled more than 180 days (6 months) during the WY in question. Hospital - Identified children with at least one hospital claim and the total stay was more than 180 days (6 months). ICF - Identified children with at least one approved/paid ICF claim and where the total stay was more than 180 days (6 months).

We used the 20/21 APC, which is the draft CMS 372 values for that year. The value we included for WY1 is trended for 2 years at an annual value of 6.809%.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Community Habilitation	
Day Habilitation	
Prevocational Services	
Respite	
Supported Employment	
Adaptive and Assistive Technology	
Caregiver/Family Advocacy and Support Services	
Environmental Modifications	
Financial Management Services	
Non-Medical Transportation	
Palliative care - Expressive Therapy	
Palliative care – Counseling and Support Service	
Palliative care – Massage Therapy	
Palliative care – Pain and Symptom Management	
Transitional Care Coordination	
Transitional Services	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Community Habilitation Total:							***5543597.97***
Community Habilitation Capitated	☐	*15 min*	*1*	*0.01*	*0.01*	***0.00***	
Community Habilitation	☐	*15 min*	*938*	*472.41*	*12.51*	***5543438.46***	
Community Habilitation Group of 2	☐	*15 min*	*7*	*1.05*	*9.76*	***71.74***	
Community Habilitation Group of 3	☐	*15 min*	*11*	*1.05*	*7.60*	***87.78***	
Community Habilitation Group of 3 Capitated	☐	*15 min*	*1*	*0.01*	*0.01*	***0.00***	
Community Habilitation Group of 2 Capitated	☐	*15 min*	*1*	*0.01*	*0.01*	***0.00***	
Day Habilitation Total:							***121390.39***
Day Habilitation Capitated	☐	*15 min*	*1*	*0.01*	*0.01*	***0.00***	
Day Habilitation	☐	*15 min*	*36*	*106.74*	*31.49*	***121004.73***	
Day Habilitation Group of 2	☐	*15 min*	*7*	*1.05*	*24.20*	***177.87***	
Day Habilitation Group of 2 Capitated	☐	*15 min*	*1*	*0.01*	*0.01*	***0.00***	
Day Habilitation	☐	*15 min*				***207.78***	

GRAND TOTAL:	***63987538.38***
Total: Services included in capitation:	
Total: Services not included in capitation:	*63987538.38*
Total Estimated Unduplicated Participants:	***17379***
Factor D (Divide total by number of participants):	***3681.89***
Services included in capitation:	
Services not included in capitation:	*3681.89*
Average Length of Stay on the Waiver:	*277*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group of 3			11	1.05	17.99		
Day Habilitation Group of 3 Capitated	☐	15 min	1	0.01	0.01	0.00	
Prevocational Services Total:							1428092.16
Prevocational Services Capitated	☐	15 min	1	0.01	0.01	0.00	
Prevocational Services	☐	15 min	620	100.30	22.91	1424681.26	
Prevocational Services Group of 2	☐	15 min	4	33.62	13.99	1881.38	
Prevocational Services Group of 2 Capitated	☐	15 min	1	0.01	0.01	0.00	
Prevocational Services Group of 3	☐	15 min	7	21.01	10.40	1529.53	
Prevocational Services Group of 3 Capitated	☐	15 min	1	0.01	0.01	0.00	
Respite Total:							29515614.77
Planned Respite Ind up to 6 hr Capitated	☐	15 min	1	0.01	0.01	0.00	
Planned Respite Ind up to 6 hr	☐	15 min	3787	438.30	15.88	26358292.55	
Planned Respite Ind 6-12 hr	☐	Per Diem	798	11.45	317.81	2903861.75	
Planned Respite Ind 6-12 hr Capitated	☐	Per Diem	1	0.01	0.01	0.00	
Planned Respite Ind12-24 hr	☐	Per Diem	9	2.10	622.23	11760.15	
Planned Respite Ind12-24 hr Capitated	☐	Per Diem	1	0.01	0.01	0.00	
Planned Respite Group up to 6 hr	☐	15 min	113	224.63	7.85	199258.04	
Planned Respite Group	☐	15 min	1	0.01	0.01	0.00	

GRAND TOTAL:	**63987538.38**
Total: Services included in capitation:	
Total: Services not included in capitation:	63987538.38
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**3681.89**
Services included in capitation:	
Services not included in capitation:	3681.89
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Up to 6 hr Capitated							
Planned Respite Group 6-12 hr	☐	Per Diem	7	1.05	225.50	**1657.42**	
Planned Respite Group 6-12 hr Capitated	☐	Per Diem	1	0.01	0.01	**0.00**	
Crisis Respite Up to 6 hr	☐	15 min	45	13.62	17.34	**10627.69**	
Crisis Respite Up to 6 hr Capitated	☐	15 min	1	0.01	0.01	**0.00**	
Crisis Respite 6-12 hr Capitated	☐	Per Diem	1	0.01	0.01	**0.00**	
Crisis Respite 12-24 hr	☐	Per Diem	9	4.20	732.93	**27704.75**	
Crisis Respite 12-24 hr Capitated	☐	Per Diem	1	0.01	0.01	**0.00**	
Crisis Respite 6-12 hr	☐	Per Diem	4	1.58	388.04	**2452.41**	
Planned Respite Group of 3 Up to 6 hr	☐	15 min	1	0.01	0.01	**0.00**	
Planned Respite Group of 3 Up to 6 hr (capitated)	☐	15 min	1	0.01	0.01	**0.00**	
Planned Respite Group of 3 6-12 hr	☐	Per Diem	1	0.01	0.01	**0.00**	
Planned Respite Group of 3 6-12 hr (capitated)	☐	Per Diem	1	0.01	0.01	**0.00**	
Supported Employment Total:							**54680.49**
Supported Employment	☐	15 min	54	38.59	26.24	**54680.49**	
Supported Employment Capitated	☐	15 min	1	0.01	0.01	**0.00**	
Adaptive and Assistive Technology Total:							**58034.61**
Adaptive and Assistive Technology	☐	Project	13	2.10	2125.81	**58034.61**	

GRAND TOTAL:	**63987538.38**
Total: Services included in capitation:	
Total: Services not included in capitation:	63987538.38
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**3681.89**
Services included in capitation:	
Services not included in capitation:	3681.89
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adaptive and Assistive Technology Capitated	☐	Project	1	0.01	0.01	0.00	
Caregiver/Family Advocacy and Support Services Total:							22993434.38
CFASS Level I Individual	☐	15 min	2919	139.06	31.62	12835068.35	
CFASS Level I Individual Capitated	☐	15 min	1	0.01	0.01	0.00	
CFASS Level I Individual Group of 2	☐	15 min	106	44.77	19.26	91400.64	
CFASS Level I Individual Group of 2 Capitated	☐	15 min	1	0.01	0.01	0.00	
CFASS Level I Individual Group of 3	☐	15 min	65	25.13	14.50	23685.02	
CFASS Level I Individual Group of 3 Capitated	☐	15 min	1	0.01	0.01	0.00	
CFASS Level II Individual	☐	15 min	2270	101.29	43.00	9886916.90	
CFASS Level II Individual Capitated	☐	15 min	1	0.01	0.01	0.00	
CFASS Level II Group of 2	☐	15 min	66	66.08	27.73	120938.29	
CFASS Level II Group of 2 Capitated	☐	15 min	1	0.01	0.01	0.00	
CFASS Level II Group of 3	☐	15 min	25	65.06	21.78	35425.17	
CFASS Level II Group of 3 Capitated	☐	15 min	1	0.01	0.01	0.00	
Environmental Modifications Total:							3138168.15
Environmental Modifications	☐	Project	226	4.34	3199.47	3138168.15	
Environmental Modifications Capitated	☐	Project	1	0.01	0.01	0.00	
Financial Management Services Total:							0.00

GRAND TOTAL:	**63987538.38**
Total: Services included in capitation:	
Total: Services not included in capitation:	63987538.38
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**3681.89**
Services included in capitation:	
Services not included in capitation:	3681.89
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services	☐	Project	1	0.01	0.01	**0.00**	
Non-Medical Transportation Total:							**24259.20**
Non-Medical Transportation	☐	Trip	20	54.15	22.40	**24259.20**	
Palliative care - Expressive Therapy Total:							**14947.11**
Palliative care-Expressive Therapy Capitated	☐	15 min	1	0.01	0.01	**0.00**	
Palliative care-Expressive Therapy	☐	15 min	9	79.01	21.02	**14947.11**	
Palliative care – Counseling and Support Service Total:							**26244.59**
Palliative care-Counseling	☐	15 min	4	1.05	106.67	**448.01**	
Palliative care-Counseling Capitated	☐	15 min	1	0.01	0.01	**0.00**	
Palliative care-Counseling and Support Service Per Episode	☐	Per Episode	22	0.18	2768.65	**10963.85**	
Palliative care-Counseling and Support Service Per Episode Capitated	☐	Per Episode	1	0.01	0.01	**0.00**	
Palliative care-Support Service Per Episode Upstate Low	☐	Per Episode	4	1.05	270.00	**1134.00**	
Palliative care-Support Service Per Episode Capitated Upstate Low	☐	Per Episode	1	0.01	0.01	**0.00**	
Palliative care-Support	☐					**1209.60**	

GRAND TOTAL:	**63987538.38**
Total: Services included in capitation:	
Total: Services not included in capitation:	63987538.38
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**3681.89**
Services included in capitation:	
Services not included in capitation:	3681.89
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service Per Episode Downstate Low		Per Episode	4	1.05	288.00		
Palliative care-Support Service Per Episode Capitated Downstate Low	☐	Per Episode	1	0.01	0.01	**0.00**	
Palliative care-Support Service Per Episode Downstate Medium	☐	Per Episode	4	1.05	574.80	**2414.16**	
Palliative care-Support Service Per Episode Capitated Downstate Medium	☐	Per Episode	1	0.01	0.01	**0.00**	
Palliative care-Support Service Per Episode Upstate Medium	☐	Per Episode	4	1.05	540.00	**2268.00**	
Palliative care-Support Service Per Episode Capitated Upstate Medium	☐	Per Episode	1	0.01	0.01	**0.00**	
Palliative care-Support Service Per Episode Upstate High	☐	Per Episode	4	1.05	900.00	**3780.00**	
Palliative care-Support Service Per Episode Capitated Upstate High	☐	Per Episode	1	0.01	0.01	**0.00**	
Palliative care-Support Service Per Episode Downstate High	☐	Per Episode	4	1.05	958.80	**4026.96**	
Palliative care-Support Service Per Episode Capitated	☐	Per Episode	1	0.01	0.01	**0.00**	

GRAND TOTAL:	***63987538.38***
Total: Services included in capitation:	
Total: Services not included in capitation:	*63987538.38*
Total Estimated Unduplicated Participants:	***17379***
Factor D (Divide total by number of participants):	***3681.89***
Services included in capitation:	
Services not included in capitation:	*3681.89*
Average Length of Stay on the Waiver:	*277*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Downstate High							
Palliative care – Massage Therapy Total:							***264.64***
Palliative care- Massage Therapy	☐	*15 min*	*4*	*1.05*	*63.01*	***264.64***	
Palliative care-Massage Therapy Capitated	☐	*15 min*	*1*	*0.01*	*0.01*	***0.00***	
Palliative care – Pain and Symptom Management Total:							***557.84***
Palliative care-Pain and Symptom Management Capitated	☐	*15 min*	*1*	*0.01*	*0.01*	***0.00***	
Palliative care- Pain and Symptom Management	☐	*15 min*	*4*	*1.05*	*132.82*	***557.84***	
Transitional Care Coordination Total:							***0.00***
Transitional Care Coordination	☐	*Monthly*	*1*	*0.01*	*0.01*	***0.00***	
Transitional Care Coordination Capitated	☐	*Monthly*	*1*	*0.01*	*0.01*	***0.00***	
Transitional Services Total:							***0.00***
Transitional Services	☐	*Project*	*1*	*0.01*	*0.01*	***0.00***	
Vehicle Modifications Total:							***1068252.06***
Vehicle Modifications	☐	*Project*	*59*	*2.36*	*7672.02*	***1068252.06***	
Vehicle Modifications Capitated	☐	*Project*	*1*	*0.01*	*0.01*	***0.00***	

GRAND TOTAL:	***63987538.38***
Total: Services included in capitation:	
Total: Services not included in capitation:	*63987538.38*
Total Estimated Unduplicated Participants:	***17379***
Factor D (Divide total by number of participants):	***3681.89***
Services included in capitation:	
Services not included in capitation:	*3681.89*
Average Length of Stay on the Waiver:	*277*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Habilitation Total:							**6005018.42**
Community Habilitation Capitated	☒	15 min	765	513.69	12.89	**5065420.04**	
Community Habilitation	☐	15 min	232	313.89	12.90	**939409.99**	
Community Habilitation Group of 2	☐	15 min	4	1.08	10.06	**43.46**	
Community Habilitation Group of 3	☐	15 min	6	1.08	7.83	**50.74**	
Community Habilitation Group of 3 Capitated	☒	15 min	6	1.08	7.83	**50.74**	
Community Habilitation Group of 2 Capitated	☒	15 min	4	1.08	10.06	**43.46**	
Day Habilitation Total:							**128308.00**
Day Habilitation Capitated	☒	15 min	18	92.61	32.46	**54110.17**	
Day Habilitation	☐	15 min	18	126.21	32.46	**73741.98**	
Day Habilitation Group of 2	☐	15 min	4	1.08	24.95	**107.78**	
Day Habilitation Group of 2 Capitated	☒	15 min	4	1.08	24.95	**107.78**	
Day Habilitation Group of 3	☐	15 min	6	1.08	18.54	**120.14**	
Day Habilitation Group of 3 Capitated	☒	15 min	6	1.08	18.54	**120.14**	
Prevocational							**1547995.10**

GRAND TOTAL:	**69413207.94**
Total: Services included in capitation:	50832533.18
Total: Services not included in capitation:	18580674.76
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**3994.09**
Services included in capitation:	2924.94
Services not included in capitation:	1069.15
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:							
Prevocational Services Capitated	☒	15 min	434	119.98	23.63	**1230445.29**	
Prevocational Services	☐	15 min	222	59.98	23.56	**313714.59**	
Prevocational Services Group of 2	☐	15 min	2	25.85	14.42	**745.51**	
Prevocational Services Group of 2 Capitated	☒	15 min	2	43.08	14.42	**1242.43**	
Prevocational Services Group of 3	☐	15 min	4	17.23	10.72	**738.82**	
Prevocational Services Group of 3 Capitated	☒	15 min	4	25.85	10.72	**1108.45**	
Respite Total:							**31998837.01**
Planned Respite Ind up to 6 hr Capitated	☒	15 min	2674	515.70	16.28	**22449823.70**	
Planned Respite Ind up to 6 hr	☐	15 min	1296	281.54	16.71	**6097075.29**	
Planned Respite Ind 6-12 hr	☐	Per Diem	316	11.41	340.11	**1226287.01**	
Planned Respite Ind 6-12 hr Capitated	☒	Per Diem	511	11.72	320.08	**1916933.51**	
Planned Respite Ind12-24 hr	☐	Per diem	7	2.42	621.77	**10532.78**	
Planned Respite Ind12-24 hr Capitated	☒	Per diem	2	1.08	818.26	**1767.44**	
Planned Respite Group up to 6 hr	☐	15 min	50	141.79	10.47	**74227.06**	
Planned Respite Group Up to 6 hr Capitated	☒	15 min	68	92.55	10.47	**65891.90**	
Planned Respite Group 6-12 hr	☐	Per Diem	4	1.08	250.09	**1080.39**	
Planned Respite Group	☒	Per Diem				**1080.39**	

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Factor D (Divide total by number of participants):	**3994.09**
Services included in capitation:	2924.94
Services not included in capitation:	1069.15
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
6-12 hr Capitated			4	1.08	250.09		
Crisis Respite Up to 6 hr	☐	15 min	15	10.77	17.91	2893.36	
Crisis Respite Up to 6 hr Capitated	☒	15 min	33	14.60	17.86	8604.95	
Crisis Respite 6-12 hr Capitated	☒	Per Diem	2	2.15	320.82	1379.53	
Crisis Respite 12-24 hr	☐	Per Diem	2	1.08	957.12	2067.38	
Crisis Respite 12-24 hr Capitated	☒	Per Diem	7	5.12	744.92	26697.93	
Crisis Respite 6-12 hr	☐	Per Diem	2	1.08	558.37	1206.08	
Planned Respite Group of 3 Up to 6 hr	☐	15 min	50	141.79	8.10	57424.95	
Planned Respite Group of 3 Up to 6 hr (capitated)	☒	15 min	68	92.55	8.08	50850.67	
Planned Respite Group of 3 6-12 hr	☐	Per Diem	6	1.08	232.46	1506.34	
Planned Respite Group of 3 6-12 hr (capitated)	☒	Per Diem	6	1.08	232.46	1506.34	
Supported Employment Total:							59158.66
Supported Employment	☐	15 min	31	37.56	27.25	31728.81	
Supported Employment Capitated	☒	15 min	28	36.54	26.81	27429.85	
Adaptive and Assistive Technology Total:							62253.50
Adaptive and Assistive Technology	☐	Project	11	1.26	3145.71	43599.54	
Adaptive and Assistive Technology Capitated	☒	Project	2	7.54	1237.00	18653.96	
Caregiver/Family Advocacy and Support Services							24909994.43

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Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**3994.09**
Services included in capitation:	2924.94
Services not included in capitation:	1069.15
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
CFASS Level I Individual	☐	15 min	963	75.31	32.70	**2371519.43**	
CFASS Level I Individual Capitated	☒	15 min	2113	167.59	32.57	**11533612.51**	
CFASS Level I Individual Group of 2	☐	15 min	48	40.42	20.42	**39618.07**	
CFASS Level I Individual Group of 2 Capitated	☒	15 min	61	50.19	19.50	**59701.00**	
CFASS Level I Individual Group of 3	☐	15 min	33	31.53	15.16	**15773.83**	
CFASS Level I Individual Group of 3 Capitated	☒	15 min	33	19.98	14.59	**9619.77**	
CFASS Level II Individual	☐	15 min	1007	68.54	44.54	**3074141.00**	
CFASS Level II Individual Capitated	☒	15 min	1388	124.35	44.24	**7635726.67**	
CFASS Level II Group of 2	☐	15 min	20	104.75	27.56	**57738.20**	
CFASS Level II Group of 2 Capitated	☒	15 min	48	52.06	29.46	**73617.00**	
CFASS Level II Group of 3	☐	15 min	13	129.23	22.52	**37833.37**	
CFASS Level II Group of 3 Capitated	☒	15 min	13	4.15	20.27	**1093.57**	
Environmental Modifications Total:							**3394843.80**
Environmental Modifications	☐	Project	200	1.64	8788.30	**2882562.40**	
Environmental Modifications Capitated	☒	Project	33	21.24	730.87	**512281.40**	
Financial Management Services Total:							**59022.88**
Financial Management Services	☐	Project	25	3.95	597.70	**59022.88**	
Non-Medical Transportation Total:							**25634.52**

GRAND TOTAL:	**69413207.94**
Total: Services included in capitation:	50832533.18
Total: Services not included in capitation:	18580674.76
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**3994.09**
Services included in capitation:	2924.94
Services not included in capitation:	1069.15
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Non-Medical Transportation	☐	Trip	20	55.51	23.09	**25634.52**	
Palliative care - Expressive Therapy Total:							**29649.33**
Palliative care-Expressive Therapy Capitated	☒	15 min	7	97.73	21.67	**14824.66**	
Palliative care-Expressive Therapy	☐	15 min	7	97.73	21.67	**14824.66**	
Palliative care – Counseling and Support Service Total:							**27503.86**
Palliative care-Counseling	☐	15 min	2	1.08	109.96	**237.51**	
Palliative care-Counseling Capitated	☒	15 min	2	1.08	109.96	**237.51**	
Palliative care-Counseling and Support Service Per Episode	☐	Per Episode	11	0.18	2854.02	**5650.96**	
Palliative care-Counseling and Support Service Per Episode Capitated	☒	Per Episode	11	0.18	2854.02	**5650.96**	
Palliative care-Support Service Per Episode Upstate Low	☐	Per Episode	2	1.08	278.33	**601.19**	
Palliative care-Support Service Per Episode Capitated Upstate Low	☒	Per Episode	2	1.08	278.33	**601.19**	
Palliative care-Support Service Per Episode Downstate Low	☐	Per Episode	2	1.08	296.88	**641.26**	
Palliative care-Support	☒	Per Episode	2	1.08	296.88	**641.26**	

GRAND TOTAL:	**69413207.94**
Total: Services included in capitation:	50832533.18
Total: Services not included in capitation:	18580674.76
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**3994.09**
Services included in capitation:	2924.94
Services not included in capitation:	1069.15
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service Per Episode Capitated Downstate Low							
Palliative care-Support Service Per Episode Downstate Medium	☐	Per Episode	2	1.08	592.52	**1279.84**	
Palliative care-Support Service Per Episode Capitated Downstate Medium	☒	Per Episode	2	1.08	592.52	**1279.84**	
Palliative care-Support Service Per Episode Upstate Medium	☐	Per Episode	2	1.08	556.65	**1202.36**	
Palliative care-Support Service Per Episode Capitated Upstate Medium	☒	Per Episode	2	1.08	556.65	**1202.36**	
Palliative care-Support Service Per Episode Upstate High	☐	Per Episode	2	1.08	927.75	**2003.94**	
Palliative care-Support Service Per Episode Capitated Upstate High	☒	Per Episode	2	1.08	927.75	**2003.94**	
Palliative care-Support Service Per Episode Downstate High	☐	Per Episode	2	1.08	988.36	**2134.86**	
Palliative care-Support Service Per Episode Capitated Downstate High	☒	Per Episode	2	1.08	988.36	**2134.86**	
Palliative care – Massage Therapy Total:							**280.58**

GRAND TOTAL:	**69413207.94**
Total: Services included in capitation:	50832533.18
Total: Services not included in capitation:	18580674.76
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**3994.09**
Services included in capitation:	2924.94
Services not included in capitation:	1069.15
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Palliative care- Massage Therapy	☐	15 min	2	1.08	64.95	**140.29**	
Palliative care-Massage Therapy Capitated	☒	15 min	2	1.08	64.95	**140.29**	
Palliative care – Pain and Symptom Management Total:							**591.45**
Palliative care-Pain and Symptom Management Capitated	☒	15 min	2	1.08	136.91	**295.73**	
Palliative care- Pain and Symptom Management	☐	15 min	2	1.08	136.91	**295.73**	
Transitional Care Coordination Total:							**0.00**
Transitional Care Coordination	☐	Monthly	1	0.01	0.01	**0.00**	
Transitional Care Coordination Capitated	☐	Monthly	1	0.01	0.01	**0.00**	
Transitional Services Total:							**0.00**
Transitional Services	☐	Project	1	0.01	0.01	**0.00**	
Vehicle Modifications Total:							**1164116.40**
Vehicle Modifications	☐	Project	48	1.16	19926.66	**1109516.43**	
Vehicle Modifications Capitated	☒	Project	13	7.08	593.22	**54599.97**	

GRAND TOTAL:	**69413207.94**
Total: Services included in capitation:	50832533.18
Total: Services not included in capitation:	18580674.76
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**3994.09**
Services included in capitation:	2924.94
Services not included in capitation:	1069.15
Average Length of Stay on the Waiver:	277

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total*

Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Community Habilitation Total:							***7013980.21***
Community Habilitation Capitated	☒	*15 min*	*784*	*526.53*	*14.34*	***5919545.12***	
Community Habilitation	☐	*15 min*	*237*	*321.74*	*14.35*	***1094221.65***	
Community Habilitation Group of 2	☐	*15 min*	*4*	*1.10*	*11.19*	***49.24***	
Community Habilitation Group of 3	☐	*15 min*	*6*	*1.10*	*8.71*	***57.49***	
Community Habilitation Group of 3 Capitated	☒	*15 min*	*6*	*1.10*	*8.71*	***57.49***	
Community Habilitation Group of 2 Capitated	☒	*15 min*	*4*	*1.10*	*11.19*	***49.24***	
Day Habilitation Total:							***154406.50***
Day Habilitation Capitated	☒	*15 min*	*19*	*94.93*	*36.11*	***65130.52***	
Day Habilitation	☐	*15 min*	*19*	*129.37*	*36.11*	***88759.46***	
Day Habilitation Group of 2	☐	*15 min*	*4*	*1.10*	*27.75*	***122.10***	
Day Habilitation Group of 2 Capitated	☒	*15 min*	*4*	*1.10*	*27.75*	***122.10***	
Day Habilitation Group of 3	☐	*15 min*	*6*	*1.10*	*20.63*	***136.16***	
Day Habilitation Group of 3 Capitated	☒	*15 min*	*6*	*1.10*	*20.63*	***136.16***	
Prevocational Services Total:							***1809831.81***
Prevocational Services Capitated	☒	*15 min*	*445*	*122.98*	*26.28*	***1438201.91***	

GRAND TOTAL:	***81715287.18***
Total: Services included in capitation:	*58639249.97*
Total: Services not included in capitation:	*23076037.21*
Total Estimated Unduplicated Participants:	***17379***
Factor D (Divide total by number of participants):	***4701.96***
Services included in capitation:	*3374.14*
Services not included in capitation:	*1327.81*
Average Length of Stay on the Waiver:	*277*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services	☐	15 min	228	61.48	26.20	367256.93	
Prevocational Services Group of 2	☐	15 min	2	26.49	16.04	849.80	
Prevocational Services Group of 2 Capitated	☒	15 min	2	44.15	16.04	1416.33	
Prevocational Services Group of 3	☐	15 min	4	17.66	11.93	842.74	
Prevocational Services Group of 3 Capitated	☒	15 min	4	26.49	11.93	1264.10	
Respite Total:							37333723.95
Planned Respite Ind up to 6 hr Capitated	☒	15 min	2741	528.59	18.11	26238948.59	
Planned Respite Ind up to 6 hr	☐	15 min	1328	288.58	18.59	7124324.52	
Planned Respite Ind 6-12 hr	☐	Per Diem	324	11.70	378.33	1434173.36	
Planned Respite Ind 6-12 hr Capitated	☒	Per Diem	524	12.01	356.05	2240708.10	
Planned Respite Ind12-24 hr	☐	Per Diem	8	2.48	691.63	13721.94	
Planned Respite Ind12-24 hr Capitated	☒	Per Diem	2	1.10	910.21	2002.46	
Planned Respite Group up to 6 hr	☐	15 min	51	145.30	11.65	86330.00	
Planned Respite Group Up to 6 hr Capitated	☒	15 min	7	94.90	11.65	7739.10	
Planned Respite Group 6-12 hr	☐	Per Diem	4	1.10	278.19	1224.04	
Planned Respite Group 6-12 hr Capitated	☒	Per Diem	4	1.10	278.19	1224.04	
Crisis Respite Up to 6 hr	☐	15 min	15	11.04	19.92	3298.75	

GRAND TOTAL:	**81715287.18**
Total: Services included in capitation:	58639249.97
Total: Services not included in capitation:	23076037.21
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**4701.96**
Services included in capitation:	3374.14
Services not included in capitation:	1327.81
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Crisis Respite Up to 6 hr Capitated	☒	15 min	34	14.96	19.87	10106.68	
Crisis Respite 6-12 hr Capitated	☒	Per Diem	2	2.21	356.87	1577.37	
Crisis Respite 12-24 hr	☐	Per Diem	2	1.10	1064.67	2342.27	
Crisis Respite 12-24 hr Capitated	☒	Per Diem	8	5.24	828.63	34736.17	
Crisis Respite 6-12 hr	☐	Per Diem	2	1.10	621.11	1366.44	
Planned Respite Group of 3 Up to 6 hr	☐	15 min	51	145.34	9.01	66785.18	
Planned Respite Group of 3 Up to 6 hr (capitated)	☒	15 min	70	94.87	8.99	59701.69	
Planned Respite Group of 3 6-12 hr	☐	Per Diem	6	1.10	258.58	1706.63	
Planned Respite Group of 3 6-12 hr (capitated)	☒	Per Diem	6	1.10	258.58	1706.63	
Supported Employment Total:							68642.33
Supported Employment	☐	15 min	32	38.50	30.32	37354.24	
Supported Employment Capitated	☒	15 min	28	37.46	29.83	31288.09	
Adaptive and Assistive Technology Total:							70032.25
Adaptive and Assistive Technology	☐	Project	13	2.21	2437.60	70032.25	
Adaptive and Assistive Technology Capitated	☒	Project	1	0.01	0.01	0.00	
Caregiver/Family Advocacy and Support Services Total:							29106843.56
CFASS Level I Individual	☐	15 min	987	77.19	36.37	2770904.10	
CFASS Level I	☒					13480294.64	

GRAND TOTAL:	**81715287.18**
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Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**4701.96**
Services included in capitation:	3374.14
Services not included in capitation:	1327.81
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Capitated		15 min	2166	171.78	36.23		
CFASS Level I Individual Group of 2	☐	15 min	49	41.44	22.72	46134.32	
CFASS Level I Individual Group of 2 Capitated	☒	15 min	62	51.44	21.69	69175.48	
CFASS Level I Individual Group of 3	☐	15 min	34	32.32	16.87	18538.11	
CFASS Level I Individual Group of 3 Capitated	☒	15 min	34	20.48	16.23	11301.27	
CFASS Level II Individual	☐	15 min	1032	70.26	49.54	3592062.17	
CFASS Level II Individual Capitated	☒	15 min	1422	127.46	49.21	8919219.99	
CFASS Level II Group of 2	☐	15 min	21	107.37	30.66	69131.25	
CFASS Level II Group of 2 Capitated	☒	15 min	49	53.37	32.77	85697.81	
CFASS Level II Group of 3	☐	15 min	13	132.46	25.05	43135.60	
CFASS Level II Group of 3 Capitated	☒	15 min	13	4.26	22.55	1248.82	
Environmental Modifications Total:							3964869.89
Environmental Modifications	☐	Project	237	4.56	3668.73	3964869.89	
Environmental Modifications Capitated	☒	Project	1	0.01	0.01	0.00	
Financial Management Services Total:							757674.41
Financial Management Services	☐	Project	313	4.05	597.70	757674.40	
Non-Medical Transportation Total:							30685.03
Non-Medical Transportation	☐	Trip	21	56.90	25.68	30685.03	
Palliative care - Expressive							20012.75

GRAND TOTAL:	**81715287.18**
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Factor D (Divide total by number of participants):	**4701.96**
Services included in capitation:	3374.14
Services not included in capitation:	1327.81
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapy Total:							
Palliative care-Expressive Therapy Capitated	☒	15 min	2	14.35	24.11	**691.96**	
Palliative care-Expressive Therapy	☐	15 min	8	100.17	24.11	**19320.79**	
Palliative care – Counseling and Support Service Total:							**30928.25**
Palliative care-Counseling	☐	15 min	2	1.10	122.31	**269.08**	
Palliative care-Counseling Capitated	☒	15 min	2	1.10	122.31	**269.08**	
Palliative care-Counseling and Support Service Per Episode	☐	Per Episode	11	0.18	3174.73	**6285.97**	
Palliative care-Counseling and Support Service Per Episode Capitated	☒	Per Episode	11	0.18	3174.73	**6285.97**	
Palliative care-Support Service Per Episode Upstate Low	☐	Per Episode	2	1.10	309.60	**681.12**	
Palliative care-Support Service Per Episode Capitated Upstate Low	☒	Per Episode	2	1.10	309.60	**681.12**	
Palliative care-Support Service Per Episode Downstate Low	☐	Per Episode	2	1.10	330.24	**726.53**	
Palliative care-Support Service Per Episode Capitated Downstate Low	☒	Per Episode	2	1.10	330.24	**726.53**	

GRAND TOTAL:	**81715287.18**
Total: Services included in capitation:	58639249.97
Total: Services not included in capitation:	23076037.21
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**4701.96**
Services included in capitation:	3374.14
Services not included in capitation:	1327.81
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Palliative care-Support Service Per Episode Downstate Medium	☐	Per Episode	2	1.10	659.11	**1450.04**	
Palliative care-Support Service Per Episode Capitated Downstate Medium	☒	Per Episode	2	1.10	659.11	**1450.04**	
Palliative care-Support Service Per Episode Upstate Medium	☐	Per Episode	2	1.10	619.20	**1362.24**	
Palliative care-Support Service Per Episode Capitated Upstate Medium	☒	Per Episode	2	1.10	619.20	**1362.24**	
Palliative care-Support Service Per Episode Upstate High	☐	Per Episode	2	1.10	1032.00	**2270.40**	
Palliative care-Support Service Per Episode Capitated Upstate High	☒	Per Episode	2	1.10	1032.00	**2270.40**	
Palliative care-Support Service Per Episode Downstate High	☐	Per Episode	2	1.10	1099.43	**2418.75**	
Palliative care-Support Service Per Episode Capitated Downstate High	☒	Per Episode	2	1.10	1099.43	**2418.75**	
Palliative care – Massage Therapy Total:							**317.90**
Palliative care- Massage Therapy	☐	15 min	2	1.10	72.25	**158.95**	
Palliative care-Massage	☒	15 min	2	1.10	72.25	**158.95**	

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Total: Services not included in capitation:	23076037.21
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**4701.96**
Services included in capitation:	3374.14
Services not included in capitation:	1327.81
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapy Capitated							
Palliative care – Pain and Symptom Management Total:							**670.12**
Palliative care-Pain and Symptom Management Capitated	☒	15 min	2	1.10	152.30	**335.06**	
Palliative care- Pain and Symptom Management	☐	15 min	2	1.10	152.30	**335.06**	
Transitional Care Coordination Total:							**0.00**
Transitional Care Coordination	☐	Monthly	1	0.01	0.01	**0.00**	
Transitional Care Coordination Capitated	☐	Monthly	1	0.01	0.01	**0.00**	
Transitional Services Total:							**0.00**
Transitional Services	☐	Project	1	0.01	0.01	**0.00**	
Vehicle Modifications Total:							**1352668.24**
Vehicle Modifications	☐	Project	62	2.48	8797.27	**1352668.24**	
Vehicle Modifications Capitated	☒	Project	1	0.01	0.01	**0.00**	

GRAND TOTAL:	**81715287.18**
Total: Services included in capitation:	58639249.97
Total: Services not included in capitation:	23076037.21
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Factor D (Divide total by number of participants):	**4701.96**
Services included in capitation:	3374.14
Services not included in capitation:	1327.81
Average Length of Stay on the Waiver:	277

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Habilitation Total:							**7863761.32**
Community Habilitation Capitated	☒	15 min	803	539.70	15.31	**6635034.02**	
Community Habilitation	☐	15 min	243	329.78	15.33	**1228493.16**	
Community Habilitation Group of 2	☐	15 min	4	1.13	11.95	**54.01**	
Community Habilitation Group of 3	☐	15 min	6	1.13	9.30	**63.05**	
Community Habilitation Group of 3 Capitated	☒	15 min	6	1.13	9.30	**63.05**	
Community Habilitation Group of 2 Capitated	☒	15 min	4	1.13	11.95	**54.01**	
Day Habilitation Total:							**169000.61**
Day Habilitation Capitated	☒	15 min	19	97.30	38.56	**71285.87**	
Day Habilitation	☐	15 min	19	132.60	38.56	**97148.06**	
Day Habilitation Group of 2	☐	15 min	4	1.13	29.64	**133.97**	
Day Habilitation Group of 2 Capitated	☒	15 min	4	1.13	29.64	**133.97**	
Day Habilitation Group of 3	☐	15 min	6	1.13	22.03	**149.36**	
Day Habilitation Group of 3 Capitated	☒	15 min	6	1.13	22.03	**149.36**	
Prevocational Services Total:							**2030912.15**
Prevocational Services Capitated	☒	15 min	456	126.05	28.07	**1613429.92**	
Prevocational Services	☐	15 min	234	63.01	27.99	**412694.08**	
Prevocational Services Group of 2	☐	15 min	2	27.15	17.14	**930.70**	

GRAND TOTAL:	**92174442.79**
Total: Services included in capitation:	66003564.26
Total: Services not included in capitation:	26170878.53
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**5303.78**
Services included in capitation:	3797.89
Services not included in capitation:	1505.89
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Group of 2 Capitated	☒	15 min	2	45.26	17.14	1551.51	
Prevocational Services Group of 3	☐	15 min	4	18.10	12.74	922.38	
Prevocational Services Group of 3 Capitated	☒	15 min	4	27.15	12.74	1383.56	
Respite Total:							41957539.75
Planned Respite Ind up to 6 hr Capitated	☒	15 min	2809	541.81	19.34	29434402.57	
Planned Respite Ind up to 6 hr	☐	15 min	1361	295.79	19.86	7995043.97	
Planned Respite Ind 6-12 hr	☐	Per Diem	332	11.99	404.09	1608552.98	
Planned Respite Ind 6-12 hr Capitated	☒	Per Diem	537	12.31	380.29	2513895.64	
Planned Respite Ind12-24 hr	☐	Per Diem	8	2.55	738.73	15070.09	
Planned Respite Ind12-24 hr Capitated	☒	Per Diem	2	1.13	972.19	2197.15	
Planned Respite Group up to 6 hr	☐	15 min	52	148.97	12.44	96365.71	
Planned Respite Group Up to 6 hr Capitated	☒	15 min	71	97.24	12.44	85886.26	
Planned Respite Group 6-12 hr	☐	Per Diem	4	1.13	297.14	1343.07	
Planned Respite Group 6-12 hr Capitated	☒	Per Diem	4	1.13	297.14	1343.07	
Crisis Respite Up to 6 hr	☐	15 min	15	11.31	21.28	3610.15	
Crisis Respite Up to 6 hr Capitated	☒	15 min	35	15.34	21.22	11393.02	
Crisis Respite 6-12 hr	☒	Per Diem	2	2.26	381.17	1722.89	

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Services included in capitation:	3797.89
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Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Capitated							
Crisis Respite 12-24 hr	☐	Per Diem	2	1.13	1137.16	2569.98	
Crisis Respite 12-24 hr Capitated	☒	Per Diem	8	5.37	885.05	38021.75	
Crisis Respite 6-12 hr	☐	Per Diem	2	1.13	663.41	1499.31	
Planned Respite Group of 3 Up to 6 hr	☐	15 min	52	148.97	9.63	74598.22	
Planned Respite Group of 3 Up to 6 hr (capitated)	☒	15 min	71	97.24	9.60	66278.78	
Planned Respite Group of 3 6-12 hr	☐	Per Diem	6	1.13	276.19	1872.57	
Planned Respite Group of 3 6-12 hr (capitated)	☒	Per Diem	6	1.13	276.19	1872.57	
Supported Employment Total:							77645.33
Supported Employment	☐	15 min	33	39.47	32.38	42175.27	
Supported Employment Capitated	☒	15 min	29	38.39	31.86	35470.06	
Adaptive and Assistive Technology Total:							82377.27
Adaptive and Assistive Technology	☐	Project	14	2.26	2603.58	82377.27	
Adaptive and Assistive Technology Capitated	☒	Project	1	0.01	0.01	0.00	
Caregiver/Family Advocacy and Support Services Total:							32667829.77
CFASS Level I Individual	☐	15 min	1012	79.12	38.85	3110697.74	
CFASS Level I Individual Capitated	☒	15 min	2220	176.08	38.70	15127737.12	
CFASS Level I Individual Group of 2	☐	15 min	50	42.47	24.26	51516.11	

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Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**5303.78**
Services included in capitation:	3797.89
Services not included in capitation:	1505.89
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CFASS Level I Individual Group of 2 Capitated	☒	15 min	64	52.73	23.17	**78192.26**	
CFASS Level I Individual Group of 3	☐	15 min	35	33.13	18.02	**20895.09**	
CFASS Level I Individual Group of 3 Capitated	☒	15 min	35	20.99	17.34	**12738.83**	
CFASS Level II Individual	☐	15 min	1058	72.01	52.91	**4031031.95**	
CFASS Level II Individual Capitated	☒	15 min	1458	130.64	52.56	**10011267.19**	
CFASS Level II Group of 2	☐	15 min	21	110.06	32.75	**75693.76**	
CFASS Level II Group of 2 Capitated	☒	15 min	50	54.70	35.00	**95725.00**	
CFASS Level II Group of 3	☐	15 min	14	135.77	26.76	**50864.87**	
CFASS Level II Group of 3 Capitated	☒	15 min	14	4.36	24.08	**1469.84**	
Environmental Modifications Total:							**4456309.06**
Environmental Modifications	☐	Project	243	4.68	3918.53	**4456309.06**	
Environmental Modifications Capitated	☒	Project	1	0.01	0.01	**0.00**	
Financial Management Services Total:							**1038510.45**
Financial Management Services	☐	Project	333	4.25	733.80	**1038510.45**	
Non-Medical Transportation Total:							**33594.07**
Non-Medical Transportation	☐	Trip	21	58.32	27.43	**33594.07**	
Palliative care - Expressive Therapy Total:							**8319.31**
Palliative care-Expressive Therapy Capitated	☒	15 min	8	14.71	25.75	**3030.26**	

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Factor D (Divide total by number of participants):	**5303.78**
Services included in capitation:	3797.89
Services not included in capitation:	1505.89
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Palliative care-Expressive Therapy	☐	15 min	2	102.70	25.75	**5289.05**	
Palliative care – Counseling and Support Service Total:							**35603.35**
Palliative care-Counseling	☐	15 min	2	1.13	130.64	**295.25**	
Palliative care-Counseling Capitated	☒	15 min	2	1.13	130.64	**295.25**	
Palliative care-Counseling and Support Service Per Episode	☐	per episode	12	0.19	3390.89	**7731.23**	
Palliative care-Counseling and Support Service Per Episode Capitated	☒	Per Episode	12	0.19	3390.89	**7731.23**	
Palliative care-Support Service Per Episode Upstate Low	☐	Per Episode	2	1.13	330.68	**747.34**	
Palliative care-Support Service Per Episode Capitated Upstate Low	☒	Per Episode	2	1.13	330.68	**747.34**	
Palliative care-Support Service Per Episode Downstate Low	☐	Per Episode	2	1.13	352.73	**797.17**	
Palliative care-Support Service Per Episode Capitated Downstate Low	☒	Per Episode	2	1.13	352.73	**797.17**	
Palliative care-Support Service Per Episode Downstate Medium	☐	Per Episode	2	1.13	703.98	**1590.99**	

GRAND TOTAL:	***92174442.79***
Total: Services included in capitation:	*66003564.26*
Total: Services not included in capitation:	*26170878.53*
Total Estimated Unduplicated Participants:	***17379***
Factor D (Divide total by number of participants):	***5303.78***
Services included in capitation:	*3797.89*
Services not included in capitation:	*1505.89*
Average Length of Stay on the Waiver:	*277*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Palliative care-Support Service Per Episode Capitated Downstate Medium	☒	Per Episode	2	1.13	703.98	**1590.99**	
Palliative care-Support Service Per Episode Upstate Medium	☐	Per Episode	2	1.13	661.36	**1494.67**	
Palliative care-Support Service Per Episode Capitated Upstate Medium	☒	Per Episode	2	1.13	661.36	**1494.67**	
Palliative care-Support Service Per Episode Upstate High	☐	Per Episode	2	1.13	1102.27	**2491.13**	
Palliative care-Support Service Per Episode Capitated Upstate High	☒	Per Episode	2	1.13	1102.27	**2491.13**	
Palliative care-Support Service Per Episode Downstate High	☐	Per Episode	2	1.13	1174.29	**2653.90**	
Palliative care-Support Service Per Episode Capitated Downstate High	☒	Per Episode	2	1.13	1174.29	**2653.90**	
Palliative care – Massage Therapy Total:							**348.81**
Palliative care- Massage Therapy	☐	15 min	2	1.13	77.17	**174.40**	
Palliative care-Massage Therapy Capitated	☒	15 min	2	1.13	77.17	**174.40**	
Palliative care – Pain and Symptom Management							**735.27**

GRAND TOTAL:	**92174442.79**
Total: Services included in capitation:	66003564.26
Total: Services not included in capitation:	26170878.53
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Factor D (Divide total by number of participants):	**5303.78**
Services included in capitation:	3797.89
Services not included in capitation:	1505.89
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Palliative care-Pain and Symptom Management Capitated	☒	15 min	2	1.13	162.67	**367.63**	
Palliative care- Pain and Symptom Management	☐	15 min	2	1.13	162.67	**367.63**	
Transitional Care Coordination Total:							**164853.00**
Transitional Care Coordination	☐	Monthly	2	3.00	4227.00	**25362.00**	
Transitional Care Coordination Capitated	☒	Monthly	11	3.00	4227.00	**139491.00**	
Transitional Services Total:							**59644.00**
Transitional Services	☐	Project	13	1.00	4588.00	**59644.00**	
Vehicle Modifications Total:							**1527459.28**
Vehicle Modifications	☐	Project	64	2.54	9396.28	**1527459.28**	
Vehicle Modifications Capitated	☒	Project	1	0.01	0.01	**0.00**	

GRAND TOTAL:	**92174442.79**
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Total: Services not included in capitation:	26170878.53
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Factor D (Divide total by number of participants):	**5303.78**
Services included in capitation:	3797.89
Services not included in capitation:	1505.89
Average Length of Stay on the Waiver:	277

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Habilitation Total:							**8826375.29**
Community Habilitation Capitated	☒	15 min	823	553.19	16.36	**7448305.05**	
Community Habilitation	☐	15 min	249	338.02	16.37	**1377813.46**	
Community Habilitation Group of 2	☐	15 min	4	1.16	12.76	**59.21**	
Community Habilitation Group of 3	☐	15 min	6	1.16	9.94	**69.18**	
Community Habilitation Group of 3 Capitated	☒	15 min	6	1.16	9.94	**69.18**	
Community Habilitation Group of 2 Capitated	☒	15 min	4	1.16	12.76	**59.21**	
Day Habilitation Total:							**194749.81**
Day Habilitation Capitated	☒	15 min	20	99.73	41.19	**82157.57**	
Day Habilitation	☐	15 min	20	135.92	41.19	**111970.90**	
Day Habilitation Group of 2	☐	15 min	4	1.16	31.66	**146.90**	
Day Habilitation Group of 2 Capitated	☒	15 min	4	1.16	31.66	**146.90**	
Day Habilitation Group of 3	☐	15 min	6	1.16	23.53	**163.77**	
Day Habilitation Group of 3 Capitated	☒	15 min	6	1.16	23.53	**163.77**	
Prevocational Services Total:							**2275539.42**
Prevocational Services Capitated	☒	15 min	467	129.20	29.98	**1808885.27**	
Prevocational Services	☐	15 min	239	64.59	29.89	**461412.23**	
Prevocational Services Group of 2	☐	15 min	2	27.83	18.30	**1018.58**	

GRAND TOTAL:	**105032530.21**
Total: Services included in capitation:	75200447.44
Total: Services not included in capitation:	29832082.77
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**6043.65**
Services included in capitation:	4327.09
Services not included in capitation:	1716.56
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Group of 2 Capitated	☒	15 min	2	46.39	18.30	1697.87	
Prevocational Services Group of 3	☐	15 min	4	18.56	13.61	1010.41	
Prevocational Services Group of 3 Capitated	☒	15 min	4	27.83	13.61	1515.07	
Respite Total:							47090443.05
Planned Respite Ind up to 6 hr Capitated	☒	15 min	2880	555.35	20.66	33043769.28	
Planned Respite Ind up to 6 hr	☐	15 min	1395	303.19	21.21	8970770.56	
Planned Respite Ind 6-12 hr	☐	Per Diem	340	12.29	431.61	1803525.55	
Planned Respite Ind 6-12 hr Capitated	☒	Per Diem	550	12.62	406.19	2819364.79	
Planned Respite Ind12-24 hr	☐	Per Diem	8	2.61	789.03	16474.95	
Planned Respite Ind12-24 hr Capitated	☒	Per Diem	2	1.16	1038.38	2409.04	
Planned Respite Group up to 6 hr	☐	15 min	53	152.69	13.29	107550.26	
Planned Respite Group Up to 6 hr Capitated	☒	15 min	73	99.67	13.29	96696.84	
Planned Respite Group 6-12 hr	☐	Per Diem	4	1.16	317.37	1472.60	
Planned Respite Group 6-12 hr Capitated	☒	Per Diem	4	1.16	317.37	1472.60	
Crisis Respite Up to 6 hr	☐	15 min	16	11.60	22.72	4216.83	
Crisis Respite Up to 6 hr Capitated	☒	15 min	36	15.72	22.66	12823.75	
Crisis Respite 6-12 hr	☒	Per Diem	2	2.32	407.12	1889.04	

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Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Capitated							
Crisis Respite 12-24 hr	☐	Per Diem	2	1.16	1214.59	**2817.85**	
Crisis Respite 12-24 hr Capitated	☒	Per Diem	8	5.51	945.31	**41669.26**	
Crisis Respite 6-12 hr	☐	Per Diem	2	1.16	708.58	**1643.91**	
Planned Respite Group of 3 Up to 6 hr	☐	15 min	53	152.69	10.28	**83191.62**	
Planned Respite Group of 3 Up to 6 hr (capitated)	☒	15 min	73	99.67	10.25	**74578.08**	
Planned Respite Group of 3 6-12 hr	☐	Per Diem	6	1.16	294.99	**2053.13**	
Planned Respite Group of 3 6-12 hr (capitated)	☒	Per Diem	6	1.16	294.99	**2053.13**	
Supported Employment Total:							**87730.29**
Supported Employment	☐	15 min	34	40.45	34.58	**47557.87**	
Supported Employment Capitated	☒	15 min	30	39.35	34.03	**40172.42**	
Adaptive and Assistive Technology Total:							**90322.01**
Adaptive and Assistive Technology	☐	Project	14	2.32	2780.85	**90322.01**	
Adaptive and Assistive Technology Capitated	☒	Project	1	0.01	0.01	**0.00**	
Caregiver/Family Advocacy and Support Services Total:							**36661813.99**
CFASS Level I Individual	☐	15 min	1037	81.10	41.49	**3489338.04**	
CFASS Level I Individual Capitated	☒	15 min	2276	180.48	41.34	**16981334.32**	
CFASS Level I Individual Group of 2	☐	15 min	51	43.53	25.92	**57543.18**	

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Services included in capitation:	4327.09
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Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CFASS Level I Individual Group of 2 Capitated	☒	15 min	65	54.05	24.74	**86917.80**	
CFASS Level I Individual Group of 3	☐	15 min	36	33.95	19.24	**23515.13**	
CFASS Level I Individual Group of 3 Capitated	☒	15 min	36	21.52	18.52	**14347.81**	
CFASS Level II Individual	☐	15 min	1085	73.81	56.52	**4526339.20**	
CFASS Level II Individual Capitated	☒	15 min	1494	133.91	56.14	**11231454.86**	
CFASS Level II Group of 2	☐	15 min	22	112.81	34.98	**86814.06**	
CFASS Level II Group of 2 Capitated	☒	15 min	51	56.07	37.39	**106919.32**	
CFASS Level II Group of 3	☐	15 min	14	139.16	28.58	**55680.70**	
CFASS Level II Group of 3 Capitated	☒	15 min	14	4.47	25.72	**1609.56**	
Environmental Modifications Total:							**5002318.37**
Environmental Modifications	☐	Project	249	4.80	4185.34	**5002318.37**	
Environmental Modifications Capitated	☒	Project	1	0.01	0.01	**0.00**	
Financial Management Services Total:							**1298533.57**
Financial Management Services	☐	Project	380	4.36	783.76	**1298533.57**	
Non-Medical Transportation Total:							**38534.19**
Non-Medical Transportation	☐	Trip	22	59.78	29.30	**38534.19**	
Palliative care - Expressive Therapy Total:							**23982.20**
Palliative care- Expressive Therapy Capitated	☒	15 min	2	15.08	27.50	**829.40**	

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Factor D (Divide total by number of participants):	**6043.65**
Services included in capitation:	4327.09
Services not included in capitation:	1716.56
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Palliative care-Expressive Therapy	☐	15 min	8	105.24	27.50	**23152.80**	
Palliative care – Counseling and Support Service Total:							**38598.70**
Palliative care-Counseling	☐	15 min	2	1.16	139.54	**323.73**	
Palliative care-Counseling Capitated	☒	15 min	2	1.16	139.54	**323.73**	
Palliative care-Counseling and Support Service Per Episode	☐	per episode	12	0.19	3621.78	**8257.66**	
Palliative care-Counseling and Support Service Per Episode Capitated	☒	Per Episode	12	0.19	3621.78	**8257.66**	
Palliative care-Support Service Per Episode Upstate Low	☐	Per Episode	2	1.16	353.20	**819.42**	
Palliative care-Support Service Per Episode Capitated Upstate Low	☒	Per Episode	2	1.16	353.20	**819.42**	
Palliative care-Support Service Per Episode Downstate Low	☐	Per Episode	2	1.16	376.74	**874.04**	
Palliative care-Support Service Per Episode Capitated Downstate Low	☒	Per Episode	2	1.16	376.74	**874.04**	
Palliative care-Support Service Per Episode Downstate Medium	☐	Per Episode	2	1.16	751.92	**1744.45**	

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Factor D (Divide total by number of participants):	**6043.65**
Services included in capitation:	4327.09
Services not included in capitation:	1716.56
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Palliative care-Support Service Per Episode Capitated Downstate Medium	☒	Per Episode	2	1.16	751.92	**1744.45**	
Palliative care-Support Service Per Episode Upstate Medium	☐	Per Episode	2	1.16	706.39	**1638.82**	
Palliative care-Support Service Per Episode Capitated Upstate Medium	☒	Per Episode	2	1.16	706.39	**1638.82**	
Palliative care-Support Service Per Episode Upstate High	☐	Per Episode	2	1.16	1177.32	**2731.38**	
Palliative care-Support Service Per Episode Capitated Upstate High	☒	Per Episode	2	1.16	1177.32	**2731.38**	
Palliative care-Support Service Per Episode Downstate High	☐	Per Episode	2	1.16	1254.24	**2909.84**	
Palliative care-Support Service Per Episode Capitated Downstate High	☒	Per Episode	2	1.16	1254.24	**2909.84**	
Palliative care – Massage Therapy Total:							**382.48**
Palliative care- Massage Therapy	☐	15 min	2	1.16	82.43	**191.24**	
Palliative care-Massage Therapy Capitated	☒	15 min	2	1.16	82.43	**191.24**	
Palliative care – Pain and Symptom Management							**806.15**

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Factor D (Divide total by number of participants):	**6043.65**
Services included in capitation:	4327.09
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Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Palliative care-Pain and Symptom Management Capitated	☒	15 min	2	1.16	173.74	**403.08**	
Palliative care- Pain and Symptom Management	☐	15 min	2	1.16	173.74	**403.08**	
Transitional Care Coordination Total:							**1443839.44**
Transitional Care Coordination	☐	Monthly	6	6.15	4514.82	**166596.86**	
Transitional Care Coordination Capitated	☒	Monthly	46	6.15	4514.82	**1277242.58**	
Transitional Services Total:							**262465.42**
Transitional Services	☐	Project	52	1.03	4900.40	**262465.42**	
Vehicle Modifications Total:							**1696095.83**
Vehicle Modifications	☐	Project	65	2.60	10036.07	**1696095.83**	
Vehicle Modifications Capitated	☒	Project	1	0.01	0.01	**0.00**	

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