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 a group 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 waiver target group, check each of the subgroups in the selected target group 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 SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged	65		
		Disabled (Physical)	0	64	
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Mental Retardation or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Mental Retardation			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

Individuals who are diagnosed by a physician as having AIDS, infected with the etiologic agent of AIDS, or who have an illness or disability attributable to such infection are a subgroup of the LTHHCP. This subgroup is referenced as the AIDS Home Care Program (AHCP).

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:

In the LTHHCP, the transition is invisible to the participant between this waiver application catigorization between individuals with disabilities (0-64) and individuals 65 and over. The available services and program processes remain the same.

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)

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:

In the LTHHCP, the LOC assessment is determined in advance of waiver participation by use of the New York State Long Term Care Placemnt Form Medical Assessment Abstract (DMS-1), or the Pediatric Patient Review Instrument (PPRI)for individuals under the age of 18, which assesses the medical and functional needs of an individual. In addition, a comprehensive assessment of an individual's medical, functional, psychosocial, and supportive needs is completed, which along with the Home Assessment Abstract (HAA) consolidates all of the assessed needs and strengths. This may also identify safe substitutes which are more cost effective services such as the use of assistive technology devices, e.g. grab bars in a bathroom, a one time ramp installation or Meals on Wheels as opposed to extra Personal Care hours for food preparation, along with utilizing informal supports. These efficiencies allow for an individual to maintain independence while enhancing their strengths and allowing for their needs to be met.

This assessment provides a Summary of Services which the individual requires to be maintained safely and leads to the plan of care. The Summary of Services includes all services, including waiver services and informal supports. A proposed budget is developed from the Summary of Services accounting for the assessed needs and all payor sources.

The LTHHCP utilizes what is known as an annualized budget. The annualized budget is the result of the process by which the costs of care for an individual are averaged over the year so that care costs that may exceed the expenditure cap in one or more months do not limit the use of the LTHHCP. The intent of the annualized budget is to encourage the use of the LTHHCP when it can be reasonably anticipated that the total Medicaid expenditures for a 12-month period will not exceed 100% of the average nursing facility rate in the individual's county of residence.

The individual's LTHHCP expenditure cap is calculated at 75% of the average nursing facility rate in the individual's county of residence; however, LTHHCP services may be provided to persons with special needs, up to 100% of the average nursing facility rate in the county of residence. If an individual is a resident of an Adult Care Facility (ACF), their expenditure cap is 50% of the average nursing facility rate in the individual's county of residence, which accounts for services provided by the ACF.

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:

LTHHCP participants also have the option to accumulate paper credits. Monthly paper credits may be accumulated and used at a later date if service needs exceed the expenditure cap. A paper credit is the difference between the costs of Medicaid services utilized in a month and the applicable expenditure cap. If the individual uses services in an amount less than the expenditure cap for a given month, a paper credit is accrued. When calculating paper credits, a look back period is used to determine available credit, using only the previous 11 months and the current month. Previous unused paper credits, prior to the 11 month period, are not available for use. The LDSS is responsible for tracking and authorizing use of paper credits which can be used in the event of a period of higher service needs.

Both paper credits and annualization of the budget are effective in addressing a participant's fluctuations in his/her needs. In addition, LDSS staff and LTHHCP agency staff consider other means of maintaining the budget within the limit, including: maximization of third party resources; increased use of informal supports including community social services and/or family; and service substitution. For example, it may be possible to use the waiver service of "moving assistance" to relocate a participant closer to a family member; the family member is then able to provide informal support on a more frequent basis lowering the participant's budget for paid assistance. Alternatively, initiating attendance at adult day health care may be a more cost effective means of providing coordinated services. Each case is unique and requires discussion with the participant about his/her options and choices.

The cost limit is not adjusted if an individual participant exceeds his/her paper credit amount. However, within the cost limit, safeguards do exist to maximize the participant's ability to be served by the waiver

These credits may be used for:
o Additional services following the exacerbation of an illness
o Increased service needs due to caregiver illness or absence
o Equipment purchases
o Other needs which are identified in the plan of care

Participants are informed of and referred to other options as necessary. In New York State, this can include the range of existing State Plan home care services as well as other available 1915c waivers such as the Nursing Home Transition and Diversion Waiver.

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	22349
Year 2	23020
Year 3	23711
Year 4	14218
Year 5	**1501**

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	
Year 2	
Year 3	
Year 4	
Year 5	

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).

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:

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

In the LTHHCP, evaluations for level of care are provided to all applicants for whom there is reasonable indication services may be needed. All individuals are assessed for meeting nursing facility LOC upon application for the program. An individual must elect to participate in the waiver program, and there must be available resources to assure the health and welfare of the individual within the community.

Appendix B: Participant Access and Eligibility

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

Waiver Phase-In/Phase-Out Schedule
Based on Waiver Proposed Effective Date: 09/01/10

a. **The waiver is being** (select one):

Phased-in

Phased-out

b. **Phase-In/Phase-Out Time Schedule.** *Complete the following table:*

Beginning (base) number of Participants: 22349

Phase-In/Phase-Out Schedule

Waiver Year 1
Unduplicated Number of Participants: 22349

Month	Base Number of Participants	Change	Participant Limit
Sep	22349	0	22349
Oct	22349	0	22349
Nov	22349	0	22349
Dec	22349	0	22349
Jan	22349	0	22349
Feb	22349	0	22349
Mar	22349	0	22349
Apr	22349	0	22349
May	22349	0	22349
Jun	22349	0	22349
Jul	22349	0	22349
Aug	22349	0	22349

Waiver Year 2
Unduplicated Number of Participants: 23020

Month	Base Number of Participants	Change	Participant Limit
Sep	22349	0	22349
Oct	22349	0	22349
Nov	22349	0	22349
Dec	22349	0	22349
Jan	22349	0	22349
Feb	22349	0	22349
Mar	22349	0	22349
Apr	22349	0	22349
May	22349	0	22349
Jun	22349	0	22349
Jul	22349	0	22349
Aug	22349	0	22349

Waiver Year 3
Unduplicated Number of Participants: 23711

Month	Base Number of Participants	Change	Participant Limit
Sep	22349	0	22349
Oct	22349	0	22349
Nov	22349	0	22349
Dec	22349	0	22349
Jan	22349	1500	20849
Feb	20849	1500	19349
Mar	19349	1500	17849
Apr	17849	1500	16349

Waiver Year
Unduplicated Number of Participants: 14218

Month	Base Number of Participants	Change	Participant Limit
Sep	12856	750	12106
Oct	12106	750	11356
Nov	11356	750	10606
Dec	10606	1500	9106
Jan	9106	1467	7639
Feb	7639	750	6889
Mar	6889	750	6139
Apr	6139	750	5389

Phase-In/Phase-Out Schedule

Month	Base Number of Participants	Change	Participant Limit
May	16349	768	15581
Jun	15581	1225	14356
Jul	14356	750	13606
Aug	13606	750	12856

Month	Base Number of Participants	Change	Participant Limit
May	5389	750	4639
Jun	4639	1500	3139
Jul	3139	1500	1639
Aug	1639	1500	139

Waiver Year 5
Unduplicated Number of Participants: 1501

Month	Base Number of Participants	Change	Participant Limit
Sep	139	0	139
Oct	139	0	139
Nov	139	0	139
Dec	139	0	139
Jan	139	0	139
Feb	139	0	139
Mar	139	0	139
Apr	139	0	139
May	139	0	139
Jun	139	0	139
Jul	139	0	139
Aug	139	0	139

c. Waiver Years Subject to Phase-In/Phase-Out Schedule

Year One	Year Two	Year Three	Year Four	Year Five

d. Phase-In/Phase-Out Time Period

	Month	Waiver Year
Waiver Year: First Calendar Month	Sep	
Phase-in/Phase-out begins	Jan	3
Phase-in/Phase-out ends	Aug	4

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

§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)

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

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 §1902(a)(10)(A)(ii)(XIII)) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §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 §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 §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:

Children who qualify under 1902(a)(10)(A)(i)(IV) of the Social Security Act for infants under one year of age, 1902(a)(10)(A)(i)(VI) children who have attained one year of age but have not attained six years of age and 1902 (a)(10)(A)(i)(VII) children who have attained six years of age but have not attained 19 years of age, and children who qualify under 1902(a)(10)(A)(ii)(VIII) State adoption assistance for children with special needs. Also included are children who were receiving SSI on August 22, 1996, and whose SSI was discontinued due to the change in disability criteria as enacted by section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PROWRA). Under the BBA of 1997, these children are deemed to be receiving SSI if they continue to meet the income and resource requirements for SSI (section 1902(a)(10)(A)(i)(II).

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 spenddown 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 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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 *(select one):*

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 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

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 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

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 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §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 §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-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:

The LOC evaluations and reevaluations are performed by a NYS licensed Registered Nurse(RN) from the LTHHCP agency or the facility from which the applicant/participant is being discharged or the individual's attending physician.

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 DMS-1 and the Pediatric PRI are the tools used for the initial evaluation and reevaluation of LOC. The DMS-1 and Pediatric PRI must be a face to face assessment which is completed by a NYS licensed Registered Nurse (RN) or physician, or a facility RN if the individual is hospitalized or residing in a nursing facility at the time of evaluation.

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.

A physician or RN must complete the New York State Long Term Care Placement Form Medical Assessment Abstract (DMS-1) and the Pediatric PRI. The DMS-1 and Pediatric PRI are the instruments used to evaluate an individual's current medical condition. To ensure accurate completion of the LOC evaluation, NYSDOH issued written guidelines for the DMS-1 assessment tool in the LTHHCP Reference Manual released to LDSSs and LTHHCP agencies in August 2006. The LDSS staff reviews 100% of all DMS-1 and Pediatric PRI forms submitted for applicants/participants. If there appear to be discrepancies in the documentation or scoring, the LDSS staff confers with the LTHHCP agency to discuss and resolve all identified issues. If agreement is not reached, the LDSS local professional director reviews the case and makes the final decision regarding the issue. NYSDOH waiver management staff provides technical assistance as needed and reviews the DMS-1 or Pediatric PRI upon request by either party to assist in resolving disagreements.

A DMS-1 score of 60 or greater indicates an individual is eligible for nursing facility care. An indicator score of 60-179 equates to a proxy calculation for a lower level of care (historically referred to as Health Related Facility (HRF)). A score greater than 180 indicates a Skilled Nursing Facility (SNF) level of care. Expenditure caps are calculated at 50%, 75%, and 100% of HRF or SNF. The individual expenditure cap is calculated using the average nursing facility rate in the county of residence. This cost control mechanism provides cost neutrality assurance.

Policy allows the local professional director or other designated physician of the applicant/participant's choice to provide override justification of the indicator score limits when an individual does not score a minimum of 60 on the DMS-1. The written physician override justification must include, but is not limited to, the medical, psychosocial, and/or rehabilitative needs which would otherwise require an individual to be institutionalized if it were not for the LTHHCP services.

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 Patient Review Instrument (PRI) is the assessment tool used to evaluate whether an individual in need of long term care services can be considered for home and community based services or whether nursing facility (NF) placement is necessary, primarily due to a lack of informal caregivers needed to support the individual in the home environment. The intent is to support the State's policy to maintain all appropriate individuals in the least restrictive environment assuring that individuals can remain safely in their own home when possible with appropriate long term care services. The next step in the evaluation process would then be to determine eligibility for services based on whether the individual chooses to remain in his/her home and community or wishes to seek NF placement.

The assessment tool used for determining LTHHCP eligibility is the DMS-1, which is comparable to the PRI in the information it captures. The DMS-1 had been the instrument used to evaluate eligibility for NF placement prior to implementation of the PRI process. The DMS-1 was replaced with the PRI when the HRF/SNF payment levels were eliminated and payment was changed to resource utilization groups (RUGS). However, the information collected on the PRI remained consistent with the information on the DMS-1, that is, identification of medical conditions or diagnoses, medical nursing treatments needed, level of assistance needed with activities of daily living (ADL), cognitive and behavioral needs and therapies needed. Individuals with minimal care needs, that is, requiring some assistance with ADLs and having minimal cognitive impairment are those individuals who would be eligible for NF placement but would fall into the lowest paying RUGS category with the expectation that they would consume minimal amounts of NF staffing resources. Similarly, they are the individuals that would score in the lower range of the DMS-1 tool as well. In NYS, both NFs and the LTHHCP have patients that are at these minimal care needs as well as those having progressively higher needs.

To assure that the DMS-1 is completed accurately, it is reviewed by the LDSS as part of the LTHHCP authorization process and is also part of the case record review by NYSDOH waiver management staff. In addition, NYSDOH surveillance staff review the DMS-1 upon LTHHCP agency survey to assure that needs have been identified, reflected on the plan of care, and consistent with the information on the DMS-1 used for program eligibility determinations.

The Pediatric PRI is the nursing facility assessment tool used for children under 18 years of age under New York's Care at Home I/II Waiver.

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 LOC Evaluation/Reevaluation determinations are conducted by the State through its agents, the Local Departments of Social Services (LDSS), which are assigned responsibility for the administration of the waiver under State Statute. Responsibilities in this role include determination of the level of care for all applicants for whom there is reasonable indication services may be needed and periodic redeterminations for participants according to approved waiver procedures.

The LTHHCP waiver employs the current LOC instrument, the Long Term Care Placement Form Medical Assessment Abstract (DMS-1) and the Pediatric Patient Review Instrument (PPRI) to determine a potential waiver participant's initial level of care and redetermination.

In the LTHHCP, all individuals are assessed for meeting nursing facility LOC upon application into the program, at least every 180 days after acceptance into the program and more frequently as circumstances warrant such as when a waiver participant has experienced significant changes in health status, including physical, cognitive or behavioral status.
The following steps are taken:

- To assess the individual, a licensed medical professional examines/interviews/ assesses, in a face to face visit, the applicant/participant. The licensed professional can be the LTHHCP agency RN, the individual's attending physician, or a facility RN, if the individual is hospitalized or residing in a nursing facility at the time of assessment.
- The assessor completes the DMS-1 or PPRI and signs attesting to the validity of the assessment. It is then forwarded by the assessor to the LDSS.
- LDSS staff reviews the completed form to assure all sections are complete, the form is signed and dated appropriately, and all indicators are scored accurately. The LDSS staff reviews 100% of all DMS-1 and PPRI forms submitted for applicants/ participants.
- If there appear to be discrepancies in the documentation or scoring of the DMS-1, or the PPRI, the LDSS staff confers with the assessor to discuss and resolve all identified

issues. If agreement is not reached, the LDSS local professional director reviews the case and makes final decision regarding the issue.
- o NYSDOH waiver management staff provides technical assistance as needed and reviews the DMS-1 or PPRI upon request by either party to assist in resolving disagreements.

To promote accurate completion and scoring of the LOC assessment, NYSDOH issued written guidelines for the DMS-1 assessment tool in the LTHHCP Reference Manual which was released to LDSSs and LTHHCP agencies in August 2006.

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:

Every 180 days

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):*

NYSDOH waiver management staff specifically monitors LOC determination by the DMS-1 and PPRI forms in a random case record review to assure:
- o Timeliness of LOC determination
- o Completion of the entire instrument
- o Accuracy in scoring
- o Appropriate signatures and dates
- o A score of 60 or higher on the DMS-1, as evidence the individual meets NF eligibility criteria or completed PPRI showing the medical needs of an individual under 18 years of age
- o When a physician override is used, in the case of an individual's predictor score not reflecting the true status with regard to the level of care required, the written physician override justification must include, but is not limited to, the medical, psychosocial, and/or rehabilitative needs which would otherwise require an individual to be institutionalized if it were not for the LTHHCP services.

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 LDSS and the LTHHCP agency are both responsible for the safe retention of all records for at least three (3) years. The records will be maintained in both agencies ensuring that they will be readily retrievable if requested by CMS or the NYSDOH Waiver Management Staff.

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**
   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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 percentage of all new enrollees who have a level of care indicating need for nursing facility level of care, prior to receipt of services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LDSS Case 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 = 95% Random sample statewide of 375 case record reviews annually and additional records reviewed as needed to monitor local district and provider performance5%
☐ **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**
	☐ **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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 percentage of enrolled waiver participants who are reevaluated at least every 180 days (or more frequently as circumstances warrant)

Data Source (Select one):
Other
If 'Other' is selected, specify:
LDSS Case Records

Responsible Party for 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% Random sample statewide of 375 case record reviews annually and additional records reviewed as needed to monitor local district and provider performance
☐ 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:	**Annually**
	Continuously and Ongoing
	Other Specify:

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 percentage of LOC determinations made by qualified evaluator

Data Source (Select one):
Other
If 'Other' is selected, specify:
LDSS Case Record

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% Random sample statewide of 375 case record

		reviews annually and additional records reviewed as needed to monitor local district and provider performance.
☐ **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**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
Number and percentage of LOC determination (initial and annual) made on the State's approved form.

Data Source (Select one):
Other

If 'Other' is selected, specify:
LDSS Case 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 = 95% Random sample statewide of 375 case record reviews annually and additional records reviewed as needed to monitor local district and provider performance.
☐ **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:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:
Number and percentage of LOC criteria that was applied correctly.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LDSS Case 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 = 95% [illegible] sample statewide of 375 case record reviews annually and additional records reviewed as needed to monitor local district and provider performance.
☐ 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**
	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.
Several strategies are employed:

NYSDOH surveillance staff monitors all LTHHCP agencies that operate in New York State by standard periodic inspections that include state certification surveys, federal initial certification surveys and recertification surveys to ensure the agency meets federal (Medicare) and State regulations, which govern them. LTHHCP agencies are surveyed at a maximum interval of 36 months to determine the quality of care and services furnished by the agency as measured by indicators of medical, nursing and rehabilitative care.

In accordance with protocols developed pursuant to the Department's Quality Management Action Plan, all significant issues/deficiencies identified by NYSDOH surveillance staff during survey or by complaint investigation are shared on a monthly basis with NYSDOH waiver management staff.

In addition to the annual case record reviews, NYSDOH waiver management staff also monitors LOC adequacy during the LDSS administrative reviews.

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. In addition, provide information on the methods used by the State to document these items.
Several methods are employed:

When a survey identifies regulatory requirements have not been met, the deficiency is identified to the LTHHCP agency operator in a written report to which the LTHHCP agency operator must respond with a corrective action plan. A plan of correction(s) must be submitted by the LTHHCP agency operator for each deficiency cited. The plan of correction is reviewed and accepted by NYSDOH based on remediation of the deficiency(s).

NYSDOH waiver management staff will notify the LDSS contact in the affected district of issues discovered through NYSDOH survey and complaint processing that would require investigation or intervention with the LTHHCP participant who may be at risk. NYSDOH waiver management staff provides necessary follow up/technical assistance. A summary of issues identified, remediation and follow up will be maintained in the Technical Assistance database and be tracked and trended.

When problems are discovered from the annual case record reviews or during the LDSS administrative reviews conducted by NYSDOH waiver management staff, further investigation and remediation actions will be triggered. Problem findings identified are discussed with LDSS program staff and provided in a written report to the LDSS Commissioner and subsequent case record review is planned for evidence of compliance with remediation.

NYSDOH waiver management staff will convene as needed regional meetings/focus groups with LDSS staff and LTHHCP agencies to discuss identified issues and potential solutions.

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**
	☑ **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.
In accordance with the CMS Quality Assurance Review Action Plan submitted by DOH:

• An electronic uniform assessment tool has been identified for use in NYSDOH long-term home and community based services and is expected to be phased in during State fiscal year 2011-2012 for the LTHHCP. This project is being coordinated by the Division of Policy and Planning within the Office of Long Term Care.

• The Office of Long Term Care has a current initiative under way to develop a uniform data set and has identified many sources of data elements. The uniform data set development project is complete and resulted in the identification of an electronic uniform assessment tool. This project is coordinated by the Division of Policy and Planning within the Office of Long Term Care.

• DOH waiver management staff has met with data management staff to begin identifying potential data sources to be used in creating quarterly management reports with key variables such as participant enrollment, expenditures, service utilization. The NYSDOH Home Health and Hospice Profile website has been identified as a data source for information regarding LTHHCP agency's services provided, counties served, inspection reports, enforcement actions that may have been taken against the agency and quality measure performance rankings.

• The agenda for the October 2008 LTHHCP Technical Assistance Group conference call included discussion regarding LDSS input of ongoing tracking, reporting elements, and data gathering in relation to LOC; specifically, the development of a required tracking system for use by the LDSS to include processing information related to length of time between the application and LOC assessment/reassessment, for assurance of compliance with timeliness. A follow up discussion and draft process was reviewed in January 2009 for expected implementation by early 2009.

• NYSDOH waiver management staff developed and implemented the LDSS' tracking system. Quarterly submission of LDSS data reports began in July 2009 and are ongoing.

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).

The LTHHCP waiver recognizes its responsibility to inform potential waiver participants of their right to Freedom of Choice. The LDSS, in the initial meeting with the potential waiver participant, informs him/her that they have a choice between living in a nursing home or living in the community supported by available services and supports, including services available through this waiver. Each potential waiver participant signs a Freedom of Choice form signifying his/her preference.

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.

For all waiver participants who have chosen waiver services and have been approved to participate in the waiver program, copies of the completed Freedom of Choice forms will be maintained for at least three (3) years in the LDSS case record.

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):
Potential and active waiver participants with limited fluency in English must have access to services without undue hardship. LDSSs must have arrangements to provide interpretation or translation services for potential and active waiver participants who need them. This is accomplished through a variety of means including; employing bi-lingual staff, resources

from the community (e.g. local colleges) and if necessary contracting with interpreters. Those who are non-English speaking may bring a translator of their choice with them to meetings with waiver providers and/or the LDSS. However, they may not be required to bring their own translator, and no person can be denied access on the basis of a LDSS's inability to provide adequate translations.