

Application for a §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 §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 waiver's 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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The New York State (NYS) renewal application seeks to renew the 1915(c) Home and Community Based Medicaid (MA) waiver, Care at Home I/II (CAH I/II), to extend it from April 1, 2017 to December 31, 2017; after which, the waiver will transition into managed care via the 1115 authority on January 1, 2018. The CAH I/II Medicaid waiver renewal application includes few substantive changes to the currently authorized program:

The application:

- Reflects a significant decrease in the number of projected participants from the prior application. In the last waiver renewal, NYSDOH projected enrollment based on the total number of Medical eligible children with a diagnosis of physical disability and anticipated future waiver enrollment based on that number. However, this new eligibility criteria did not necessarily increase the need for waiver services and as such the increase in waiver enrollment did not occur as projected. Please refer to section B-3(a).

- Contains reference to the pending implementation of a new Uniform Assessment System (UAS-NY) for all community-based programs. The new assessment tool will replace the currently used Pediatric Patient Review Instrument to evaluate the level of care (skilled facility or hospital level of care) for CAH I/II eligibility and service need purposes. The UAS-NY will be used in conjunction with the existing LOC tool for those children in hospital and or nursing facility settings. Please refer to Section B-6 (c-d).

- Reflects administrative changes due to a reorganization within the NYS Department of Health. Specifically, the Office of Long Term Care (OLTC) was reorganized and its responsibilities, including oversight of the CAH I/II waiver, were combined with the Medicaid Assistance Unit in the Office of Health Insurance Programs (OHIP). OLTC is now a Division with OHIP.

- Amends the case management waiver service description to include a new prohibition of sole proprietor providers, and to add a credential requirement for NYS Masters in Social Work licensure for Family Palliative Care Education (Training) service providers.

- Case management services provided through the CAH I/II waiver is compliant with Conflict of Interest standards as case management providers do not provide any other waiver service. Additionally, caseload limits are now included for case management services.

- Respite services is removed from the waiver application due to under utilization.

- Pain and symptom management services is removed from the waiver to avoid duplication of available services afforded through the State Plan.

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 §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*):
Care At Home I/II
- C. **Type of Request:** renewal
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
Waiver Number: NY.4125.R05.00
Draft ID: NY.019.05.00
- D. **Type of Waiver** (*select only one*):
Regular Waiver
- E. **Proposed Effective Date:** (*mm/dd/yy*)
04/01/17
Approved Effective Date: 04/01/17

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:
- 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 §1915(a)(1)(a) of the Act and described in Appendix I**
 Waiver(s) authorized under §1915(b) of the Act.

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

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

- §1915(b)(1) (mandated enrollment to managed care)**
 §1915(b)(2) (central broker)
 §1915(b)(3) (employ cost savings to furnish additional services)
 §1915(b)(4) (selective contracting/limit number of providers)
 A program operated under §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 §1915(i) of the Act.**
 A program authorized under §1915(j) of the Act.
 A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility 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 CAH I/II 1915(c) waiver serves children under age eighteen who have physical disabilities and require either a nursing facility or hospital level of care. The purpose of the waiver is to avoid unwanted institutionalization for eligible children by providing appropriate access to Medicaid State Plan and community based long term care waiver services.

CAH I/II is operated statewide. The New York State Department of Health (NYSDOH), as the Single State Medicaid Agency, administers and provides oversight of the waiver program. The 58 New York State (NYS) Local Department Social Service (LDSS) are charged with implementing the Medicaid program, including the daily operations and administrative functions of the CAH I/II waiver. In the 5 boroughs of New York City, the LDSSs are known as Human Resources Administration (HRA).

The roles and responsibilities of the LDSS are established by the State Public Health Law, Sections 201 and 206, Social Services Law Sections 363-a and 366.6, and by the Medicaid State Plan, Appendix A, #4. In addition, NYS bulletins, specifically General Information System and Medicaid Administrative Directives, are issued and updated as needed to provide ongoing guidance regarding Medicaid program administration, including eligibility determination, system management, provider reimbursement, monitoring and corrective actions. This includes receiving referrals, explaining the program to applicants/families, ensuring the applicants/families have choice among case management agencies, assist families through the Medicaid application process, recruit case management agencies in their district and working with the case managers and families in the development and modifications of plans of care to meet participant needs.

The CAH I/II case manager, in conjunction with the child's family/legal guardian and physician, develops a Plan of Care. The plan identifies the waiver and State Plan services necessary to maintain the waiver participant safely in the home and community. All CAH I/II services are delivered by NYSDOH enrolled Medicaid providers; the exception being that home/vehicle modifications are delivered through local contractors. Palliative care providers are limited to NYS Certified Home Health Agencies (CHHA) or Hospices with employees who have completed End of Life Nursing Educational Consortium (ELNEC) or comparable training and

certification.

Subsequent to the existing CAH I/II waiver approval, the DOH organizational structure shifted to include components of the Office of Long Term Care that manage community based care as the Division of Long Term Care (DLTC) within the overarching Office of Health Insurance Programs. The Division will continue to have responsibility for administration and quality assurance for all aspects of CAH I/II waiver implementation.

While the NYS mandatory transition of Medicaid recipients from fee-for-service to managed care is anticipated to include CAH I/II participants in January 2018, this waiver renewal request reflects the necessary services and supports needed to facilitate the transition process into the 1115 Demonstration authority until that time.

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 §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 §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 §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 §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 §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §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. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule

for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, 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 §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 waiver staff work closely on a continuing basis with advocacy groups for families of children with disabilities and waiver service providers. Such groups include the Coalition for Medically Fragile Children and the Hospice and Palliative Care Association of New York State and service providers.
- Pursuant to Presidential Executive Order #13175, NYSDOH provided the State's nine federally recognized Tribal Governments with written notification of the CAH I/II waiver renewal application and all proposed substantial changes to the program and offered an opportunity for their comment.
- 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:

Segal

First Name:

Andrew

Title:

Director Division of Long Term Care

Agency:

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

Address:

One Commerce Plaza 99 Washington Avenue

Address 2:

Room 1620

City:

State: Albany
State: New York
Zip: 12260
Phone: (518) 402-5673 **Ext:** TTY
Fax: (518) 486-2564
E-mail: andrew.segal@health.ny.gov

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

Last Name: Hoffman
First Name: David
Title: Director, Bureau of Community Integration and Alzheimer's Disease
Agency: NYS Department of Health, Office of Health Insurance Programs, Division of Long Term Care
Address: One Commerce Plaza 99 Washington Avenue
Address 2: Room 1620
City: Albany
State: New York
Zip: 12260
Phone: (518) 474-5271 **Ext:** TTY
Fax: (518) 474-7067
E-mail: david.hoffman@health.ny.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification

requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

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:

Respite and pain and symptom management are removed as waiver services, not to duplicate available state plan services.

While the NYS mandatory transition of Medicaid recipients from fee-for-service to managed care will include CAH I/II child participants effective January 1, 2018, this waiver renewal request reflects the necessary services and supports needed to facilitate the transition process into the 1115 Demonstration authority until that time. Current plans include the transition of the CAH I/II 1915c waiver to children's health home services effective January 1, 2018.

Please refer to: http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/child_timeline.htm

Since CAH I/II does not currently conduct cost reporting activities compliant with CFR standards, time is required to train providers on this work to begin cost reporting activities effective December 31, 2017 should the program not transition to managed care through 1115 authority.

CAH I/II is compliant with Conflict of Interest standards.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

All waiver participants reside in their own home.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

NYSDOH has been working to ensure that all Care at Home I/II providers comply with Conflict of Interest Case Management criteria and to ensure that sufficient program structure is in place that supports CMS Conflict of Interest standards.

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 (including Medicaid), The Division of Long Term Care

(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.*

- 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:

In New York State, the Local Department of Social Services (LDSS) and Human Resource Administration (HRA) in New York City are charged with implementing the Medicaid program, including the CAH I/II 1915(c) waiver. Responsibilities of the LDSS include the on-going review of participant level of care assessment; participation in the development of and review of the comprehensive home assessment resulting in a proposed Service Plan; and authorization of participation in the waiver for applicants who qualify. HRA is the Local Department of Social Service office located in New York City which services five boroughs (Brooklyn, Queens, New York, Staten Island, and Bronx) in the metropolitan area. They function in the same capacity as other LDSSs in New York State. The function of the CAH I & II Coordinator in HRA is the same as all other LDSSs.

The operational activities and functions of the LDSS/HRA includes the review of the initial Level of Care (LOC) and the application packet to ensure the information provided justifies the skilled care and services recommended. Once it is evident that the child's LOC meets the qualifications, the child's application is forwarded by LDSS/HRA coordinators to the NYSDOH staff for final review. NYSDOH staff reviews the initial documentation and the LDSS/HRA recommendations in the application packet. NYSDOH staff signs a letter of approval or denial which is addressed to the LDSS/HRA CAH coordinator with a copy to the case manager. All subsequent evaluations and assessments are reviewed by the LDSS/HRA CAH coordinator and maintained at the LDSS/HRA.

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 System (GIS), and MA Management Administrative Directives (ADM) are issued and updated as needed to provide ongoing guidance regarding MA program administration, including eligibility determinations, system management, provider reimbursement, monitoring, and corrective action. Accordingly, no additional Memorandum of Understanding between the State and an LDSS is necessary. This includes Human Resource Administration (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/DLTC is responsible for the day-to-day operation and oversight of the CAH I/II waiver program and is, accordingly, responsible for assessing the performance of the LDSS waiver administration in respective counties which includes the roles and responsibilities of HRA Care at Home I/II coordinators.

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:

NYSDOH waiver staff oversee and monitor the administration of the CAH I/II waiver through annual case record reviews designed to assess the LDSS's/HRA's understanding of its role and responsibilities, and waiver administrative processes. All initial applications along with the level of care documents, and participant service plans are submitted to the NYSDOH for initial approval/denial. Once the applicant is enrolled in the CAH I/II waiver, NYSDOH waiver staff oversees and monitors the administration of the CAH I/II waiver through annual case record reviews designed to assess the LDSS/HRA functions.

The LDSS/HRA is required to track and submit quarterly reports regarding service applications, authorized participants, disenrolled participants, and applicants denied waiver participation. LDSS/HRA 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 LDSS waiver administrative performance.

LDSS/HRA Care at Home I/II coordinators call NYSDOH waiver staff at the time parents call in a complaint. When a complaint is received by the LDSS/HRA the complaint is copied/sent to NYSDOH waiver staff. Parents are also given NYSDOH waiver staff telephone numbers so they can call direct if needed. CAH I/II case managers also call NYSDOH waiver staff directly. This process is ongoing, not limited to quarterly reports. LDSS/HRA are responsible for investigating and responding to complaints that are received. DOH waiver staff receives a copy of complaints and conferences with the LDSS/HRA to ensure proper investigation is done according to established procedures. NYSDOH waiver staff will hold conference calls with the LDSS/HRA and the complainant if NYSDOH staff determines that the situation warrants it.

NYSDOH waiver staff participate in a variety of activities to provide technical assistance in order to maintain an open line of communication with the LDSS, and investigate complaints. For example, quarterly conference call meetings with the LDSS 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 LDSS staff.

NYSDOH waiver staff participate in training and other meetings such as the statewide Special Medicaid Technical Advisory Group (M-TAG) conference calls with LDSS Medicaid Directors and staff and regional LDSS 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 CAH I/II 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.*

Function	Medicaid Agency	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Function	Medicaid Agency	Local Non-State Entity
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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 of initial applications submitted to DOH waiver staff that are completed according to policy/procedures (Percentage=number of applications completed correctly/total number of applications submitted and reviewed by DOH waiver staff).

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percentage of case files, retrospectively reviewed each year by NYSDOH waiver staff, that require remediation and are referred to the LDSS CAH I/II Coordinator for correction. (Percentage=number of cases reviewed and returned for correction/total number of cases received).

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percentage of LDSS quarterly reports of program activity submitted to DOH waiver staff that were submitted timely and in the correct format. (Percentage = number of reports submitted correctly and timely/total number of required reports submitted)

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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.
Waiver case files:

Ten percent of waiver cases are randomly selected for review. The materials reviewed include the child's assessments, physician orders, case management plans, budgets 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. Case management notes are also reviewed in order to substantiate billings and subsequent Medicaid reimbursement.

Tracking reports:

Quarterly reports from LDSS/HRA are used as a tracking tool to monitor program activity within each district, recipient movement across district lines, and home and vehicle modifications.

Conference calls:

Quarterly Conference calls enable the sharing and peer discussion of LDSS/HRA 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. In addition, provide information on the methods used by the State to document these items.

The remediation process is initiated when the LDSS CAH I/II coordinator or NYSDOH waiver management staff identify a lack in the quality of provided services or any other issue related to administration of CAH I/II.

In such situations, the standard procedure is for NYSDOH waiver management staff and the LDSS CAH I/II coordinator to discuss the situation and collaboratively develop a plan of correction. Implementation and compliance with the plan of correction is monitored by both entities.

Should the plan of correction require a change in the participant's services, NYSDOH waiver management staff and the LDSS/HRA CAH I/II coordinator will work cooperatively to address the service deficiency and when necessary, transition the child to another CAH I/II provider. To ensure continuity of service during any transition period, the original provider will be required to transfer copies of the CAH I/II participant's case records and other pertinent documents to the new provider.

Remediation of financial issues begins immediately upon the discovery of any impropriety. NYSDOH waiver management and other NYSDOH staff, as appropriate, will immediately initiate remediation of any inappropriate claims processed through eMedNY. Remediation may include voiding payments, assigning penalties, and sanctioning providers. In the case of home and vehicle modifications, LDSS/HRA staff will initiate remediation by cancelling payments to home and vehicle contractors. The LDSS/HRA staff will initiate remediation of any inappropriate claims processed on Schedule E. The LDSS/HRA will directly recoup payments made to the provider.

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 CAH I/II services. Accordingly, NYSDOH waiver management staff will issue a letter to the provider terminating its CAH I/II waiver provider status.

Unsatisfactory home and vehicle modification contractors will be notified of their disqualification from further service by the administering LDSS/HRA. The LDSS CAH I/II coordinator will help the family find alternate contractors and craftsmen.

Documentation of remediation activities is accomplished by the following measures: correspondence between NYSDOH waiver management staff, the LDSS CAH I/II coordinator, participants and their parents/legal guardians, and/or service providers; amended plans of care; LDSS case reviews and reports of follow-up meetings with participants and their families; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file and, as appropriate, by NYSDOH.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	0	17	
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

The State further specifies its target group as those individuals under the age of eighteen who are not married. In NYS, individuals under the age of eighteen, who are married, are considered to be adults for purposes of consenting to medical treatment. Therefore, NYSDOH does not consider such individuals to be eligible for the CAH I/II as children.

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 CAH I/II ends on the day of the waiver participant's eighteenth (18) birthday. As participants reach their seventeenth (17) birthday, the CAH I/II case manager will begin to assist the enrollees in planning for transition to other services and/or programs. Waiver enrollees who reach their eighteenth birthday will 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.

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	1600
Year 2	1755
Year 3	2053
Year 4	2402
Year 5	2810

- 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	[]

Waiver Year	Maximum Number of Participants Served At Any Point During the Year		
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:

The CAH I/II waiver provides enrollment for eligible children who must be under 18 years of age, physically disabled based on SSI criteria, unmarried, require the level of care provided in a nursing facility or hospital, and be capable of being cared for in the community if provided with case management services, home/vehicle adaptations, and palliative care services. Enrollment is based on first come first served.

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

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:

42 CFR 435.145 - Children with adoption assistance, foster care, or guardianship care under title IV-E.
 42 CFR 435.227 - Optional eligibility for individuals under age 21 who are under State adoption assistance agreements.
 42 CFR 435.118 - Infants and children under age 19

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 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 periods before January 1, 2014 or after December 31, 2018.

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 7)**

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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 7)**

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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. 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:

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 registered professional nurse.

- 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 initial evaluation of level of care for CAH I/II waiver applicants is performed by a Registered Professional Nurse (RN) currently registered and licensed in the State of New York and employed by, among others, a Local Department of Social Services or Health Department, Certified Home Health Agency (CHHA), Developmental Disability Services Organization (DDSO), Community Alternative Systems Agency (CASA), authorized by NYSDOH and upon completion of mandatory training required by NYSDOH. Although other professional disciplines may contribute to the assessment as appropriate, only an RN can finalize an assessment. The RN performing the assessment must be trained in the use of the assessment tool. Training for use of the new Uniform Assessment System of New York (UAS-NY) pediatric assessment is available on-line. The training tool includes an assessment of the trainee's competency.

- 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 CAH I/II waiver services. The applicant/participant must be under the age of 18; have a favorable disability determination by the Social Services Administration (SSA), State, or LDSS Disability Review Team using SSA criteria for physical impairment; and require either a skilled nursing facility or hospital level of care.

The new Uniform Assessment System of New York (UAS-NY), utilizing the Pediatric 0-3 or the Pediatric 4-17 assessment tool for children, will be implemented statewide within sixty (60) days of waiver approval, to determine the initial level of care requirements (hospital or nursing facility) for all waiver applicants. As presently required, the assessment will be updated annually, or as required due to a change in the participant's medical or other related condition, to provide a validated level of care and service need determination to support service planning from a strength-based perspective. NYSDOH engaged internal and external statisticians to conduct field studies on the various tools (i.e. PPRI) against the Uniform Assessment tool. Field tests conducted were validated against data from the UAS-NY Beta test conducted during the summer of 2012.

Specifically, UAS-NY is a web-based software application used to establish an electronic health record, capturing all assessment information in one location. The new tool provides immediate online access to assessment outcomes and results, and facilitates sharing of information among providers as appropriate and helpful to the recipient. UAS-NY enables review of an individual's health related needs, to guide development of an individualized plan for long term care within the least restrictive setting.

The assessment has three domains: functional health, condition, and cognition status, with sub-categories such as activities of daily living, neurological condition, memory recall ability, and decision making skills. Assessment outcomes include: Level of Care and care planning assistance. CAH I/II will be utilizing this tool for Level of Care status.

- 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.

Once the UAS-NY tool is fully implemented, the currently used CAH I/II assessment tool, the Pediatric Patient Review Instrument, will be used to determine level of care only when the applicant is being cared for in a hospital or nursing home, or if a UAS-NY assessment cannot be secured in a timely manner and waiver services are necessary to ensure the health and safety of the child. If the child is enrolled in the waiver upon discharge from the institutional setting, or if the PPRI is used as an interim measure, the UAS-NY must be completed within 90 days of waiver eligibility or the completed PPRI.

- 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 currently used Pediatric Patient Review Instrument (PPRI) assessment tool is designed to evaluate the level of care (skilled facility or hospital level of care) for CAH I/II enrollment purposes. The Local Department of Social Services (LDSS) CAH coordinator and Case Manager are responsible for arranging the assessment. The PPRI assessment must be completed by a Registered Nurse (RN) designated by the LDSS prior to a child's enrollment in CAH I/II, if a UAS-NY assessment is not completed. The child must be assessed within 90 days of waiver enrollment utilizing the UAS-NY Pediatric tool.

The information collected, at a minimum, includes: family background, diagnosis, a complete description of the child's medical condition, type and frequency of needed medical 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 assessing RN needs additional information to complete the assessment and make a level of care determination accurately, he/she may directly request the information from the parent, child if appropriate, or the child's physician. In some instances, the RN will ask the LDSS CAH Coordinator to assist in obtaining the necessary information from the appropriate source. The PPRI will only be utilized for applicants who are in a hospital or nursing facility. With implementation of the UAS-NY assessment tool, the CAH I/II waiver will utilize the UAS-NY Pediatric tool (0-3 or 4-17 years old) 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 UAS-NY, and only those individuals will be able to access the web based technology.

The assessment outcomes present long term care options for the individual and identify persons who are nursing home 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 assessment will be made available to the case manager and LDSS/HRA. If there appears to be any question regarding the applicant's nursing home or hospital level of care, the selected case manager will consult with the CAH coordinator and NYSDOH to resolve any identified issues. The CAH coordinator may request that the LDSS Nurse review the completed assessments.

As part of the service plan review, the CAH coordinator reviews the assessment to confirm that the applicant meets the LOC criteria for waiver participation; confirms Medicaid eligibility; reviews medical verification to support a physical disability; and confirms the age of the applicant.

The CAH coordinator, in conjunction with the case manager, is responsible for assuring that the initial and annual LOC assessments are completed by qualified assessors and in a manner timely to waiver participation. LDSS coordinator and NYSDOH staff are able to access the UAS-NY through the Health Commerce System.

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.

Initial level of care evaluations must be completed prior to the approved enrollment date for community based individuals. Enrolled waiver participants are reevaluated annually in conjunction with the service plan 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*):

An RN authorized to implement the UAS-NY, completes the assessment instrument on an annual basis or whenever there is a change in the enrollee's medical status. In accordance with program guidelines, the CAH case managers 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 CAH coordinator maintains a file or log which indicates when each participant's level of care re-evaluation is due. This is usually part of a larger re-assessment package which may include Medicaid eligibility and disability re-certification, physician orders and case management plan of service. As part of his or her role for oversight of children in that district enrolled in the CAH I/II waiver, the CAH coordinator maintains regular contact with the CAH case managers to discuss the progress of each enrollee, identify needs, and solve problems.

NYSDOH waiver management staff and the CAH Coordinator review the participant's case record to ensure that the annual level of care and other documentation that comprises the re-assessment package was completed in a timely manner.

If there is a change in the participant's medical condition or home situation which necessitates a re-evaluation, the CAH coordinator requests a re-assessment by an RN from a designated agency. The re-assessment documentation indicates the findings of the assessing RN. In addition, all documentation for re-evaluations are submitted to the CAH coordinator.

- 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:

Local districts must retain the letter of notification, level of care determinations, home assessments, plans of care, expenditure estimates and all other information pertaining to the child's enrollment and continued eligibility for the waiver in the waiver applicant's file. 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 eighteenth 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 by the NYSDOH/DLTC.

The UAS-NY is a web-based application. All assessment information is entered directly into and stored in the web-based application. The assessment information is stored on a secure server.

The Case Manager is the primary person to arrange for the annual LOC reassessment by a certified assessor. Each Case Management Agency and LDSS/HRA 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 CAH I/II waiver applicants who have a level of care assessment completed indicating the need for a nursing home or hospital level of care prior to receiving waiver services. (Percentage=number of LOC forms present in the record/total records reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: LDSS	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: LDSS	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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.

Performance Measure:

Number and percentage of CAH I/II participants who have a LOC re-assessment completed at least annually. (Percentage=number of current LOC forms present in the record that were re-evaluated within the previous 365 days/total records reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central record review

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% confidence level

		5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 participant level of care determinations (initial, annual, or both) completed utilizing the required assessment tool. (Percentage=number of LOC

determinations (initial, annual, or both) that meet assessment requirements/total LOC determinations reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% confidence interval 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- 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. In addition, provide information on the methods used by the State to document these items.

The remediation process is initiated when the LDSS, CAH I/II coordinator or NYSDOH waiver management staff identify an issue with the quality of provided services, or any other issue related to the administration of CAH I/II.

In such situations, the standard procedure is for NYSDOH waiver management staff, the LDSS, or CAH I/II coordinator to discuss the situation and collaboratively develop a plan of correction. Implementation and compliance with the plan of correction is monitored by NYSDOH and LDSS staff.

Should the plan of correction require a change in the participant's service, the NYSDOH waiver management staff and the LDSS, CAH I/II coordinator will work cooperatively to address the service deficiency and when necessary, transition the child to another CAH I/II provider. To ensure continuity of service during the transition period, the original provider will be required to transfer the CAH I/II participant case records and other pertinent documents to the new provider.

Remediation of financial issues begins immediately upon the discovery of any impropriety. The NYSDOH waiver management staff, and other Department staff determined to be needed, will immediately initiate remediation of any inappropriate claims processed through eMedNY. Remediation may include voiding payments, assigning penalties, and sanctioning providers. In the case of issues involving home and vehicle modifications, LDSS staff will initiate remediation by cancelling payments to home and vehicle contractors. The LDSS staff will initiate remediation of any inappropriate claims processed on Schedule E.

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 CAH I/II services. Accordingly, NYSDOH waiver management staff will issue a letter to the provider terminating the provider's CAH I/II waiver provider status.

Home and vehicle modification contractors that are not performing satisfactorily will be notified of their disqualification from providing further services by the administering LDSS. The LDSS CAH I/II coordinator will help the family find alternate contractors.

Documentation of remediation activities is accomplished by the following measures: correspondence between NYSDOH waiver management staff, the LDSS CAH I/II coordinator, participants and their parents/legal guardians, and/or service providers; amended plans of care; LDSS case reviews and reports of follow-up meetings with participants and their families; and the results of NYSDOH annual reviews. All such documents are maintained by the LDSS CAH I/II coordinator in the participant's case file and, as appropriate, by NYSDOH/DLTC as well.

- 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 LDSS/HRA ensures that eligible individuals have been informed of feasible alternatives for care. The applicant's parents/legal guardians are required to sign the Choice of Care 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 LDSS and a copy is forwarded to NYSDOH.

The LDSS also informs parents/legal guardians of the case management agencies available in the LDSS catchment area. The parents/legal guardians must sign the Choice of Case Management Selection form indicating their choice of case manager for their child. This form is kept as part of the applicant's permanent case file at the LDSS and a copy is forwarded to NYSDOH.

- 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 forms are kept on file at the LDSS in the applicants' case files and copies are kept at the NYSDOH/DLTC.

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. LDSS offices 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 LDSS/HRA. However, applicants cannot be required to bring their own translator, and no person can be denied access on the basis of a District's inability to provide adequate translations. [NYS DOH GIS 99 MA/021 and 95 INF-15] All LDSS/HRA and case management agencies 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 (see attachment). 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	Case Management		
Other Service	Bereavement Services		
Other Service	Expressive Therapies		
Other Service	Family Palliative Care Education (Training)		
Other Service	Home and Vehicle Modification		
Other Service	Massage Therapy		

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:

Case Management ▼

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Case management encompasses a wide range of activities the objectives and functions of which include: assisting children and families gain access to MA State Plan and other specified community based services; developing and implementing a plan of care that meets the needs of the participant; assuring that services are provided in a cost effective manner in accordance with the plan of care; and maximizing private health insurance for covered services.

CAH I/II children may also receive services in the State's Early Intervention Program, however, CAH I/II Case management will not be reimbursed if the child is receiving duplicative case management through Early Intervention Services or Medicaid Service Coordination. The implementation of a Restriction Exception (R/E) code restricts any duplication of payment. The participant's parent/legal guardian must select a case manager before the waiver application is submitted to NYSDOH waiver management staff.

In accordance with federal and state regulations, the participant must be offered freedom of choice when choosing a MA provider at the time of application. The selected case management agency must meet the qualifications as outlined in NYS Regulations 18 NYCRR 505.16 and be enrolled as a CAH I/II case management provider. The availability of case management agencies varies throughout the State.

Agencies authorized to provide case management to a child are:

- Professional Case Management Agencies enrolled as a CAH I/II provider.

CAH I/II case managers must adhere to all Medicaid rules and regulations, and follow established program policy. Specifically, the case manager will:

- Assist children and their families to gain access to the full range of available community based services.
- Assure provided services match the particular needs of the participant and their family.
- Encourage active participation of the participant's family in the plan of care.
- Assure family and home health care providers have taken reasonable steps to maintain the child's health and safety in the community.
- Assure MA services are delivered in a cost effective manner and that alternate sources of reimbursement, such as private health insurance, are maximized.
- Assist with the development of the Plan of Care and its update, at a minimum annually, and securing necessary MD orders and assessments necessary to assure Plan of Care implementation.
- Maintain regular contact with the LDSS, CAH I/II coordinator the child and his/her parent/legal guardian. At a minimum, the case manager will maintain monthly contact with the participant. It is recommended that the case

manager accompany the assessing nurse on visits to the child's home.

At a minimum, the case manager will maintain monthly face-to-face contact with the child. It is recommended that the case manager accompany the assessing nurse on visits to the child's home. CAH Case Managers are expected to meet face-to-face with all individuals on their caseloads as frequently as needed based upon each person's individual needs and circumstances. However, there must be at least one face-to-face meeting provided each month. Face-to-face meetings and home visits are tools used by the CAH case manager to assess, identify and deliver the case management activities and interventions within the scope of CAH Case Management and the person's plan of care. Face-to-face meetings should have a purpose and an outcome (e.g. observing for health and safety). This means that it is not appropriate for face-to-face meetings to be used purely for social or recreational purposes. At least one face to face meeting will occur in the child's home every six months.

Case Managers are not permitted to provide other direct waiver services to the participant.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. In the case of Hospice/Palliative services the case manager provides linkage and referral for other services beyond the scope of Hospice/Palliative interdisciplinary team.

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

All case management is reimbursed using the existing 15 minute unit fee schedule expense reimbursement methodology.

NYSDOH will implement caseload size limits effective 10/1/17. This timeframe allows for notification of the change to provide appropriate training, support waiver participant choices, and allow for the CAH case management agencies sufficient time to hire and train new staff in order to come into compliance with this new service criteria. NYSDOH has established a maximum caseload size of no more than 30 individuals per case manager. This caseload limit is inclusive of any individual that the case manager renders case management services to, and is not limited to those individuals receiving services under this waiver. This caseload size reflects the individual case manager's scope of responsibility and accounts for the level of support required by individuals receiving services under the CAH I/II waiver.

Case management services are limited to 120 hours annually, not to exceed 10 hours monthly, unless otherwise indicated in the participant's plan of care and authorized by the LDSS.

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

- Participant-directed as specified in Appendix E
 Provider managed

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	Non Profit Organization

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency ▼

Provider Type:

Non Profit Organization

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Case Management Agencies/Case Managers: 18 NYCRR 505.16; Application to NYSDOH; as outlined in 90 ADM-20:18.

Individuals who are self-employed may not provide case management services.

Individual case management staff must meet the required educational and experience qualifications. The individual providing case management must have:

Two years of experience in a substantial number of activities outlined in this application, including the performance of assessments and development of Service Plans.

Voluntary or part-time experience which can be verified will be accepted on a prorated basis. (Provide a copy of resume highlighting relevant experience).

The following may be substituted for this requirement:

- a. one year of case management experience and a degree in a health or human services field (provide a copy of diploma & copy of resume highlighting relevant experience);
- b. one year of case management experience and an additional year of experience in other activities with the target population (provide a copy of resume highlighting relevant experience);
- c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined in this application and above mentioned directives, including the performance of assessments and development of Service Plans (provide a copy of diploma & evidence of practicum with case management experience); or
- d. meet the regulatory case management requirements of another State agency

Verification of Provider Qualifications**Entity Responsible for Verification:**

NYSDOH will verify the case management agency's qualifications.

Frequency of Verification:

Verification of the Case Management Agency is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH.

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:

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:

Bereavement Services

HCBS Taxonomy:

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

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Bereavement Services will be made available to waiver participants and their families to help them cope with grief related to the challenges of progressive and chronic illness and life-limiting conditions. This service will include, but not be limited to, opportunities for individual, family, or group counseling.

Approved service providers will be social workers, hospice bereavement staff, and/or other appropriate licensed professionals employed by a Certified Home Health Agency (CHHA) or Hospice and who have specialized training and experience working with children and their families who are in need of counseling to address end-of-life issues related to their illness.

Bereavement Services must be provided in accordance with the participant's CAH I/II plan of care and as appropriate to the participant's medical condition and challenges.

Bereavement services may be provided to informal caregivers and family supports who are unpaid caregivers, as requested by the family. The counseling must be initiated and billed while the child is participating in the CAH I/II waiver but may continue, if requested, at no charge by the provider for up to one year after the death of the child. Service is provided in the child's home.

Palliative Care providers are not permitted to provide other direct waiver services to the participant.

Note: This service is available only to the child and other persons who provide uncompensated care and support to the participant in areas specified in the service plan. Individuals who are employed to support the participant may not receive this service. This service does not duplicate other services available through the New York Medicaid State Plan.

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

Not to exceed five (5) hours daily, 120 hours annually; must be initiated prior to the death of the participant and discontinued within one year thereafter. Services will be provided in 30 minute increments.

State plan services must be exhausted or determined not sufficient to meet the needs of the individual. The service plan must indicate why the specific waiver service is necessary to the care and support of the individual and family and that it does not duplicate other available State Plan services.

It is the responsibility of the Bereavement Counselor to ensure a physician order for Bereavement Services is obtained prior to providing services, and renewed every 60 days.

Documentation for each visit must be maintained in the participant's file and available upon request.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

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	Non-Profit Organization
Agency	Non-Profit Organization

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Bereavement Services

Provider Category:

Agency ▼

Provider Type:

Non-Profit Organization

Provider Qualifications

License (specify):

Certificate (specify):

Non-profit/voluntary/private as established in NYS Public Health Law §4004

PHL Section 4008; 10 NYCRR Section 791.2

Other Standard (specify):

Hospice Agency

The Provider must employ a Bereavement Counselor who meets the following qualifications:

Clinical Social Worker currently licensed in New York State pursuant to NYS Education Law, Article 154, Social Work, preferably having three years clinical pediatric and one year clinical end of life care experience; or

Psychologist currently licensed in New York State pursuant to NYS Education Law, Article 153, Psychology, preferably having three years clinical pediatric and one year clinical end of life care experience; or

Mental Health Counselor currently licensed in New York State, pursuant to NYS Education Law, Article 163, Mental Health Practitioners, Section 8402, Mental Health Counseling, preferably having three years clinical pediatric and one year clinical end of life care experience; and must

Demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH will verify Medicaid enrollment for each provider type. The Hospice is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.

Frequency of Verification:

Verification of the Hospice agency is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The Hospice Agency must verify licensure and/or certification of employees upon hire and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Bereavement Services

Provider Category:

Agency

Provider Type:

Non-Profit Organization

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):

The Provider must employ a Bereavement Counselor who meets the following qualifications:

Clinical Social Worker currently licensed in New York State pursuant to NYS Education Law, Article 154, Social Work, preferably having three years clinical pediatric and one year clinical end of life care experience; or

Psychologist currently licensed in New York State pursuant to NYS Education Law, Article 153, Psychology, preferably having three years clinical pediatric and one year clinical end of life care experience; or

Mental Health Counselor currently licensed in New York State, pursuant to NYS Education Law, Article 163, Mental Health Practitioners, Section 8402, Mental Health Counseling, preferably having three years clinical pediatric and one year clinical end of life care experience; and must

Demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH will verify Medicaid enrollment for each provider type. The CHHA is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.

Frequency of Verification:

Verification of the CHHA is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The CHHA must verify licensure and/or certification of employees upon hire and annually 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:

Expressive Therapies

HCBS Taxonomy:

Category 1:

Sub-Category 1:

▼ ▼

Category 2:

Sub-Category 2:

▼ ▼

Category 3:

Sub-Category 3:

▼ ▼

Category 4:

Sub-Category 4:

▼ ▼

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Expressive Therapies are aimed at assisting children meet the challenges of their progressive and chronic illness and life-limiting conditions. Included specialty services are intended to help children better understand and express their reactions through professionally led creative and kinesthetic treatment modalities designed specifically for the CAH I/II participant and their sibling, if any. Certified art, music, and play therapists and child life specialists will treat emotional distress associated with the participant's diagnosis by providing age-appropriate information about the plan of care, course of treatment, end of life experience, and useful coping strategies to ease anticipatory anxiety regarding upcoming treatments and procedures.

Expressive therapies, including Music, Art, and Play therapy, must be provided in accordance with the participant's plan of care and as appropriate to the child's end of life condition and challenges.

Palliative Care providers are not permitted to provide other direct waiver services to the participant.

Note: This service does not duplicate other services available through the New York Medicaid State Plan.

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

No more than one (1) hour per week; not to exceed five (5) hours per month.

Expressive Therapy is provided in the child's home; it may not be provided in an institutional setting.

It is the responsibility of the Expressive Therapist to ensure a physician order for Expressive Therapy is obtained prior to providing services, and renewed every sixty (60) days.

Documentation for each visit must be maintained in the participants file and available upon request. Services will be reimbursed in thirty (30) minute increments.

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

- Participant-directed as specified in Appendix E**
 Provider managed

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	Non-Profit Organization
Agency	Non-Profit Organization

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expressive Therapies

Provider Category:

Agency ▼

Provider Type:

Non-Profit Organization

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*):

The Provider must employ, or ensure access to, Expressive Therapists who meet the following qualifications:

Child Life Specialist, currently certified through the Child Life Council, a national professional organization that administers a standard credentialing process, and have preferably three years clinical pediatric and one year clinical end of life care experience; or

Creative Arts Therapist, currently licensed in New York State pursuant to NYS Education Law, Article 163, Mental Health Practitioners, and have preferably three years clinical pediatric and one year clinical end of life care experience; or

Music Therapist with a Bachelor's degree in Music Therapy from a program recognized by the New York State Education Department, registered with a nationally recognized organization for Music Therapy professionals, and preferably have one year clinical end of life care experience; or

Play Therapist with a Master's degree from a program recognized by the NYS Education Department, and with the credential of Registered Play Therapist conferred by the Association for Play Therapy, and preferably have three years clinical pediatric experience, and one year clinical end of life care experience;

and

All expressive therapists must demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH will verify Medicaid enrollment for each provider type. The CHHA is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.

Frequency of Verification:

Verification of the CHHA is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The CHHA must verify licensure and/or certification of employees upon hire and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Expressive Therapies

Provider Category:

Agency ▼

Provider Type:

Non-Profit Organization

Provider Qualifications

License (specify):

Certificate (specify):

Non-profit/voluntary/private as established in NYS Public Health Law §4004.

PHL Section 4008; 10 NYCRR Section 791.2

Other Standard (specify):

Hospice Agency

The Provider must employ, or ensure access to, Expressive Therapists who meet the following qualifications:

Child Life Specialist, currently certified through the Child Life Council, a national professional organization that administers a standard credentialing process, and have preferably three years clinical pediatric and one year clinical end of life care experience; or

Creative Arts Therapist, currently licensed in New York State pursuant to NYS Education Law, Article 163, Mental Health Practitioners, and have preferably three years clinical pediatric and one year clinical end of life care experience; or

Music Therapist with a Bachelor's degree in Music Therapy from a program recognized by the New York State Education Department, registered with a nationally recognized organization for Music Therapy professionals, and preferably have one year clinical end of life care experience; or

Play Therapist with a Master's degree from a program recognized by the NYS Education Department, and with the credential of Registered Play Therapist conferred by the Association for Play Therapy, and preferably have three years clinical pediatric experience, and one year clinical end of life care experience; and

All expressive therapists must demonstrate ongoing proficiency in the principles of end of life care through

participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH will verify Medicaid enrollment for each provider type. The Hospice is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.

Frequency of Verification:

Verification of the Hospice agency is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The Hospice Agency must verify licensure and/or certification of employees upon hire and annually 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:

Family Palliative Care Education (Training)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Hospice care means a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

The Palliative Care Act is not intended to limit options available to terminally-ill patients. Nor is it intended to discourage conversations about palliative care with patients with an extended life expectancy. It may be appropriate to discuss palliative care with patients earlier in the disease progression. Therefore, in addition to these traditional services, the waiver may offer curative treatment offered outside the scope of state plan services. Medicaid State Plan services may be accessed prior to accessing waiver services. Waiver services are provided when the scope, frequency, duration, intensity of service or needs of the individual exceeds those services provided through State Plan services. State plan services solely, may not be sufficient to meet the needs of the child. Palliative services provided through the waiver can allow for the continuation of life sustaining therapies including intubation, mechanical ventilation, artificial nutrition and hydration.

Family Palliative Care Education (Family Training) provides, as appropriate, direct instruction and guidance aimed at the challenges of progressive and chronic illness and life-limiting conditions for CAH I/II waiver participants, their families and extended network of support, and other potential informal caregivers. The service may be provided by a registered professional nurse or social worker who has special training in pediatric palliative care.

Family Training providers use specialized assessment and intervention skills to address the physical, psychological and spiritual issues associated with the waiver participant's complex end of life conditions for which curative treatment may fail, is not possible, or because of which an early death is likely. This service is designed to meet the needs of each individual participant and his/her family. The service is aimed at, but not limited to, instruction in palliative principles and challenges of progressive and chronic illness and life-limiting conditions, and familiarization with the expected trajectory of a child's illness/medical treatment regimens, related services included in the participant's plan of care.

The Family Trainer will share observations and concerns regarding the child's life threatening condition and identified changing service needs related to the challenges of progressive and chronic illness and life-limiting conditions with the participant's interdisciplinary team.

Palliative Care providers are not permitted to provide other direct waiver services to the participant.

Note: This service is available only to the participant and other persons who provide uncompensated care and support to the participant in areas specified in the service plan. Individuals who are employed to support the participant may not receive this service. This service does not duplicate other services available through the New York Medicaid State Plan.

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

Not to exceed five (5) hours per day, eight (8) hours monthly, 100 hours annually. Documentation for each visit must be maintained in the participant's file and available upon request. Services will be reimbursed in 30 minute increments.

It is the responsibility of the Family Palliative Care Trainer to ensure a physician orders for Family Palliative Care Education services is obtained prior to providing services, and renewed every 60 days.

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

- Participant-directed as specified in Appendix E
 Provider managed

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	Non-Profit Organization
Agency	Non-Profit Organization

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Family Palliative Care Education (Training)****Provider Category:**

Agency ▾

Provider Type:

Non-Profit Organization

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):

The Provider must employ a Family Palliative Care Trainer who meets the following qualifications:

Registered Professional Nurse currently licensed and registered pursuant to the provisions of the New York State Education Law, Article 139, Nursing, preferably having at least three years clinical pediatric care and one year clinical end of life care experience; or

Medical Social Worker having a Master's degree in Social Work and currently licensed in New York State pursuant to NYS Education Law, Article 154, Social Work, and preferably have at least three years clinical pediatric care experience and one year clinical end of life care experience; and must

Demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications**Entity Responsible for Verification:**

NYSDOH will verify Medicaid enrollment for each provider type. The CHHA is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.

Frequency of Verification:

Verification of the CHHA is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The CHHA must verify licensure and/or certification of employees upon hire and annually thereafter.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Family Palliative Care Education (Training)****Provider Category:**

Agency ▾

Provider Type:

Non-Profit Organization

Provider Qualifications**License (specify):****Certificate (specify):**

Non-profit/voluntary/private as established in NYS Public Health Law §4004.

PHL Section 4008; 10 NYCRR Section 791.2

Other Standard (*specify*):

The Provider must employ a Family Palliative Care Trainer who meets the following qualifications:

Hospice Agency

Registered Professional Nurse currently licensed and registered pursuant to the provisions of the New York State Education Law, Article 139, Nursing, preferably having at least three years clinical pediatric care and one year clinical end of life care experience; or

Medical Social Worker having a Master's degree in Social Work and currently licensed in New York State pursuant to NYS Education Law, Article 154, Social Work, and preferably have at least three years clinical pediatric care experience and one year clinical end of life care experience; and must

Demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH will verify Medicaid enrollment for each provider type. The Hospice agency is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.

Frequency of Verification:

Verification of the Hospice agency is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The Hospice Agency must verify licensure and/or certification of employees upon hire and annually 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:

Home and Vehicle Modification

HCBS Taxonomy:

Category 1:

Sub-Category 1:

▼ ▼

Category 2:

Sub-Category 2:

▼ ▼

Category 3:

Sub-Category 3:

▼ ▼

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Modifications to the private residence of a waiver participant are provided, in accordance with the participant's plan of care, to ensure the health, welfare and safety of the child and to enable him/her greater functionality and independence in the home. Such modification may include: the installation of structural ramps, grab bars, and wheelchair or ceiling lifts; the widening of doorways; bathroom accessibility, electrical and plumbing system retro-fits. The service also includes modification of the family vehicle when required by the child's service plan to provide safe access to the community.

Excluded from this benefit are those adaptations or improvements to the home that are of general utility, including items that are installed into the home but can be removed without structurally changing the home, modifications or improvements that are not of direct medical or remedial benefit to the child, and those that add to the total square footage of the home. Also excluded are pools and hot tubs and associated modifications for entering or exiting the pool or hot tub. The scope of modifications will also include necessary assessments to determine the types of modifications needed. Also excluded are medical supplies, equipment and appliances that are covered as such under state plan MA services.

LDSS 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 Home & Vehicular Modifications, the LDSS 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.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the LDSS in conjunction with NYSDOH.

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

The maximum expenditure for Home & Vehicle Modifications for the benefit of the individual Medicaid beneficiary may not exceed \$25,000 for home and \$25,000 for vehicle modifications per five year period. If the person requires an expenditure which exceeds the maximum expenditure amount, the Single State Medicaid Agency may submit and seek approval of an amendment to the waiver; the Single State Agency shall provide supporting documentation as deemed necessary by CMS to support approval of the amendment.

Note: Children who qualify for MA under the CAH waiver through parental deeming do not qualify for CFCO and as such services for this population would not be considered an extended state plan service.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
- Provider managed**

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	Home and Vehicle Modification Contractor/Craftsman

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home and Vehicle Modification

Provider Category:

Agency ▼

Provider Type:

Home and Vehicle Modification Contractor/Craftsman

Provider Qualifications

License (specify):

Licensure appropriate to the trade

Certificate (specify):

Other Standard (specify):

LDSS staff verify the qualifications of home modification providers present the following knowledge and skills:

- Must be familiar with the home adaptation and vehicle modification policies permitted in the CAH program as described in this program manual and 00 OMM/ADM-4; the LDSS/HRA should supply the evaluator with a copy of both prior to initiation of the evaluation.
- Must be able to communicate well with all parties involved with the development of home adaptations and vehicle modifications, e.g. consumers, contractors, and local government officials.
- Must be able to clearly describe in writing, and by design, the proposed home adaptation and vehicle modification.
- 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.
- Must have knowledge of assistive technology and specific adaptive equipment appropriate for the child's needs.
- Must have skill in design/drafting in order to clearly describe the proposed modification.
- 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 CAH program is required to:

- Be bonded;
- Maintain adequate and appropriate licensure;
- Obtain any and all permits required by state and local municipality codes for the modification; and
- 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.

The ACCES-VR agency 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:

LDSS

Frequency of Verification:

Provider qualifications are verified at the beginning of the home modification contract by the LDSS and/or at the beginning of the vehicle modification contract by ACCES-VR.

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:

Massage Therapy

HCBS Taxonomy:

Category 1:

Sub-Category 1:

 

Category 2:

Sub-Category 2:

 

Category 3:

Sub-Category 3:

 

Category 4:

Sub-Category 4:

 

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Massage Therapists apply a scientific system of activity to the muscular structure of the human body for the purpose of improving muscle tone and circulation. The aim of the therapy is to promote relaxation, manage musculoskeletal pain, and relieve fear and stress associated with the challenges of progressive and chronic illness and life-limiting conditions. Massage therapy services may be complementary to physical therapy or rendered as a less intrusive alternative. Massage Therapy may be provided in the home of the participant/family or therapeutic or medical office available through the Hospice or CHHA. Massage Therapy may not be provided in an institutional setting.

The service will be provided in accordance with the participant's plan of care by NYS licensed massage therapists. Assessment to determine the specific therapeutic massage activities to be used and the need for continued therapy is also an included service.

Palliative Care providers are not permitted to provide other direct waiver services to the participant.

Note: This service does not duplicate other services available through the New York Medicaid State Plan.

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

Maximum one hour per week reimbursed in 30 minute increments; not to exceed 5 hours per month. It is the responsibility of the Massage Therapist to ensure a physician order for Massage Therapy is obtained prior to providing services, and renewed every 60 days.

Documentation for each visit must be maintained in the participant's file and available upon request.

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

- Participant-directed as specified in Appendix E
 Provider managed

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	Non-Profit Organization
Agency	Non-Profit Organization

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:

Agency ▼

Provider Type:

Non-Profit Organization

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Non-profit/voluntary/private as established in NYS Public Health Law §4004.

PHL Section 4008; 10 NYCRR Section 791.2

Other Standard (*specify*):

The Provider must employ, or ensure access to, a Massage Therapist who meets the following qualifications:

Hospice Agency

Massage Therapist currently licensed and registered in New York State pursuant to NYS Education Law, Article 155, Massage Therapy, preferably having end of life care experience; and must

Demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH will verify Medicaid enrollment for each provider type. The Hospice is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.

Frequency of Verification:

Verification of the Hospice agency is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The Hospice Agency must verify licensure and/or certification of employees upon hire and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:

Agency ▼

Provider Type:

Non-Profit Organization

Provider Qualifications

License (specify):

Certificate (specify):

Non-profit/voluntary/private as established in NYS Public Health Law §4004.

Certified Home Health Agency

PHL Sections 3602, 3606

Other Standard (specify):

The Provider must employ, or ensure access to, a Massage Therapist who meets the following qualifications:

Massage Therapist currently licensed and registered in New York State pursuant to NYS Education Law, Article 155, Massage Therapy, preferably having end of life care experience; and must

Demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH will verify Medicaid enrollment for each provider type. The CHHA is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.

Frequency of Verification:

Verification of the CHHA is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The CHHA must verify licensure and/or certification of employees upon hire and annually thereafter.

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 §1915(i) of the Act (HCBS as a State Plan Option).** Complete item C-1-c.
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** Complete item C-1-c.
- As an administrative activity.** 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:

Agencies authorized to provide case management to a child are:

Professional Case Management Agencies enrolled as a CAH I/II provider

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 and Section 845-b of the Executive Law, any certified home health agency, hospice, or licensed home care services agency, licensed or authorized under Articles 36 or 40 of the Public Health Law to provide services to patients, residents or clients shall 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 face-to-face care or supervision to patients, residents or clients.

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. 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 investigation 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 regulations (e.g., appropriate direct observation and evaluation).

A provider requesting a criminal history record check obtains the prospective employee's fingerprints, accompanied by two forms of identification, for submission to NYSDOH. Providers must maintain and retain current records, including a roster of current employees who were so reviewed, to which NYSDOH shall have immediate and unrestricted access 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 regulations. If a provider is found not to be in compliance with the regulations, a statement of deficiency(ies) is issued, and the provider has to provide a plan of correction.

- 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; and, (c) the process for ensuring that mandatory screenings have been conducted. 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 State 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 State Central Register; and
 - * To receive and handle the response from the State Central Register.
- Each provider develops its own procedures to ensure compliance.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. **Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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 to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *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 legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure 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 specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls 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 interested in approval as a CAH I/II Medicaid waiver provider. NYSDOH has a multi-level process for assuring that the providers that serve waiver participants are qualified. Division of Long Term Care(DLTC), CAH 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, as well as, the agency's case management staff qualifications. The provider must submit an application to NYSDOH waiver management staff demonstrating compliance with the qualifications and competencies necessary to meet waiver participant needs. In addition, every provider 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 or the eMedNY website. These websites explain the process and qualifications for the CAH services. Providers may also contact their LDSS/HRA or in the case of NYC, HRA, and/or DOH waiver staff for further information.

Once the agency is a participating provider of case management services for CAH, it is the applicant's ongoing responsibility to verify and maintain their employees' records showing that they have the required qualifications and certifications.

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 percentage of approved waiver provider applications that demonstrate compliance with required qualifications and competencies for CAH I/II service provision. (Percentage=the number of providers that meet qualifications at time of application/total providers reviewed in the waiver year).

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percentage of providers that demonstrate continuous compliance with required qualifications and competencies for CAH I/II service provision.

(Percentage=the number of providers that meet continuous qualifications/total providers reviewed in the waiver year.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% confidence interval 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
---	--

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 percentage of non-licensed/non-certified providers that continue to meet waiver provider qualifications where applicable in accordance with State Law and waiver provider requirements. (Percentage=non-licensed/non-certified providers that continue to meet waiver provider qualifications/total number of providers reviewed within that waiver year.)

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

On-site and central desk review

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% confidence interval

		5% margin of error
<input checked="" type="checkbox"/> Other Specify: LDSS CAH I/II Coordinator for Home and Vehicle Modifications	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: LDSS CAH I/II Coordinator for Home and Vehicle Modifications	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 percentage of CAH I/II waiver providers, where applicable, meeting provider training requirements. (Percentage=waiver provider meeting training requirements at application/total number of provider applications reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input checked="" type="checkbox"/> Annually <input type="checkbox"/> Continuously and Ongoing

- 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. In addition, provide information on the methods used by the State to document these items.

The remediation process is initiated when the LDSS CAH I/II coordinator or NYSDOH waiver management staff identify a deficiency in the quality of provided services, or any other issue related to administration of CAH I/II.

In such situations, the standard procedure is for NYSDOH waiver management staff and the LDSS CAH I/II coordinator to discuss the situation and collaboratively develop a plan of correction. Implementation and compliance with the plan of correction is monitored by NYSDOH and LDSS staff.

Should the plan of correction require a change in the participant’s service, the NYSDOH waiver management staff and the LDSS CAH I/II coordinator will work cooperatively to address the service deficiency and when necessary, transition the child to another CAH I/II provider. To ensure continuity of service during the transition period, the original provider will be required to transfer the CAH I/II participant case records and other pertinent documents to the new provider.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be determined as inappropriate to continue to provide CAH I/II services. Accordingly, NYSDOH waiver management staff will issue a letter to the provider terminating its CAH I/II waiver provider status.

Unsatisfactory home and vehicle modification contractors will be notified of their disqualification from further service by the administering LDSS. The LDSS CAH I/II coordinator will help the family find alternate contractors and craftsmen.

Documentation of remediation activities is accomplished by the following measures: correspondence between NYSDOH waiver management staff, the LDSS CAH I/II coordinator, participants’ and their parents/legal guardians, and/or service providers; amended plans of care; LDSS case reviews and reports of follow-up meetings with participants and their families; and the results of NYSDOH annual reviews. All such documents are maintained in the participant’s case file and, as appropriate, by NYSDOH/DLTC.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: LDSS CAH I/II Coordinator for Home and Vehicle Modifications	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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.

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 and how they meet federal HCB Settings requirements, at the time of submission and in the future.
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 ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

All CAH I/II waiver participants reside in their own home. The State assures that this waiver will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

CAH I/II Plan of Care

- 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 (*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:

- 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. *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.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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.

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.

Upon application, the LDSS 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 MA state plan 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 CAH I/II waiver program. The parents/legal guardians also sign the Case Management Agency Selection Form, indicating their choice for their child. A copy of each of these forms is given to the parent, and maintained in LDSS and case management agency files. Copies are also forwarded and maintained in NYSDOH CAH I/II records.

Applicants have a choice of programs as well as service providers. Each LDSS CAH I/II coordinator has a list of available waiver and State Plan MA 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 Case Management Agency, the case manager is responsible to work with the participant/parent/legal guardian continuously to:

- Provide an explanation of all services available to the child in the CAH waiver and other health and community resources that may benefit the child. This information includes range of services offered through the waiver
- Provide assistance reviewing and understanding waiver material.
- Provide the opportunity to participant/parent/legal guardian the ability to participate in the development, review, and approval of all Service Plans, including any change which ensures that the participant/parent/legal guardian has an active role in the service plan development. The service plan reflects all services to be provided to the participant including service type, frequency and duration. The service plan is signed by the parent/legal guardian verifying that they have participated in the development of the service plan.
- Provide the participant/parent/legal guardian choice of their child's service providers.

The Case Manager provides a description of the waiver services to the participant/parent /legal guardian, available to prevent placement in skilled nursing facility or institution. The Case Manager also must provide a detailed explanation of the potential participant's choices and needs to ensure that the participant/parent/legal guardian understand all waiver material.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. 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; and, (g) how and when the plan is updated, including when the participant's needs change. 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

Each Local Department of Social Services (LDSS) Commissioner designates a CAH I/II coordinator. The LDSS CAH I/II coordinator is the primary contact with NYSDOH waiver management staff, CAH I/II case managers and family of the applicant/participant. The LDSS CAH I/II coordinator has the responsibility for ensuring that the plan for waiver services, referred to in CAH I/II as the Plan of Care, is developed in accordance with waiver policy and protocols.

The service planning process begins with an assessment of the applicant's medical needs and available community supports, and determination that the applicant needs skilled nursing facility or hospital level of care as required for participation in CAH I/II. The CAH I/II case manager uses the assessment to develop a Plan of Care, and projects the cost of service (budget) for each waiver applicant.

Assessment

An assessment is completed annually prior to every service plan development. This assessment is completed by a Registered Professional Nurse. The assessment outlines the participant's health care needs. The Case Manager utilizes this assessment in the development of the participant's plan of care

The LDSS CAH I/II coordinator arranges for a Registered Nurse (RN) employed by a LDSS/HRA designated agency (e.g. Certified Home Health Agency, Developmental Disabilities Services Organization, Community Alternative Systems Agency, among others) to complete a nursing assessment. The assessment (initial and reassessment) takes into account the applicant's medical, social, habilitation and environmental needs, as well as the family's needs, strengths and abilities and is signed by the nurse who conducts the assessment.

The RN assessment also identifies all informal caregivers who are trained and available to provide skilled care for the child, including their schedules and an adequate back-up plan in the absence of skilled homecare professionals. Documentation must clearly indicate that informal caregivers have been trained in the child's care or, if they are currently engaged in training, who is providing the training and when it is anticipated that the training will be complete.

Assessment results are used to ascertain that the applicant needs skilled nursing facility or hospital level of care as required for participation in CAH I/II, and that the medical interventions are necessary for the child to be safely cared for at home.

During all steps of the assessment process, the LDSS CAH I/II coordinator and case manager remain in contact with the waiver applicant's parents/legal guardians. Case management activities related to assessment include: scheduling the assessment to accommodate the parent's schedule, serving as a conduit for the family to obtain information about the CAH I/II waiver, informing the family of the choice of providers available to render the services, and assisting the family to access knowledge about their child's medical condition and outside supports in the community

The CAH I/II case manager forwards recommendations from the assessment results to the applicant's physician. The physician reviews the information and the case manager's recommendations, and is responsible for authorizing the services (including the provider skill, frequency, duration) necessary to maintain the applicant in the community.

Service Plan

The LDSS CAH I/II coordinator reviews all documentation to determine waiver eligibility and provides copies of the assessment, and physician orders to the CAH I/II case manager in accordance NYSDOH policy guidance (04 OMM LCM-2 and GIS 13 MA/07).

The CAH I/II case manager, with the assistance and input from the child's parent(s)/legal guardian(s), uses the assessment and physician orders to design a Plan of Care that will:

- Identify CAH I/II waiver and State Plan services needed to meet the participant's community based needs;
- Identify available informal caregivers and other resources necessary for the appropriate and safe care of the child in the home;
- Ensure conformance with waiver program policies;
- Address service delivery issues;
- Verify provision of provider choice has been offered to the participant and/or parents/legal guardian; and
- Note schedule for required updates.

The CAH I/II Case Manager utilizes the RN assessment to develop the plan of care and the physician orders for applicant and participants. The CAH I/II Case Manager utilizes the RN assessment to develop the plan of care which must be authorized, by the LDSS consistent with the physician's orders. Among other things, the plan of care contains the budget projections for the cost of services for the waiver applicant

The CAH I/II case manager's recommendations for services and providers are recorded on the Case Management Plan of Services form signed by the CAH I/II case manager and the participant's parent(s)/legal guardian. The LDSS CAH I/II coordinator reviews the proposed Plan of Care, including the CAH I/II case manager's recommendations, and determines the applicant's appropriateness for CAH I/II participation.

Once the LDSS coordinator has completed the required enrollment activities, the Plan of Care with supporting documentation is forwarded to NYSDOH. Upon review of the documentation, NYSDOH waiver management staff send a letter to the LDSS CAH I/II coordinator confirming or denying the coordinator's request for applicant's enrollment in the CAH I/II waiver. Upon implementation of the UAS-NY, if a child is assessed while being cared for in a facility, the LDSS CAH I/II coordinator will arrange for reassessment within 90 days of waiver eligibility. Once the initial service plan is approved by DOH waiver staff, the LDSS/HRA Care at Home coordinator works with the case manager to ensure the service plan is implemented.

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 CAH I/II waiver services (case management, home and/or vehicle modification, and/or palliative services), and other medically necessary MA State Plan services. The Plan of Care is forwarded to the LDSS CAH I/II coordinator for review and approval.

Physician orders are required to be renewed every sixty days and are submitted by the CAH I/II case manager to the LDSS CAH I/II coordinator.

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 CAH I/II case manager and the participant's parents/legal guardian.

An assessment is completed annually prior to every service plan development. This assessment is completed by a Registered Professional Nurse. The assessment outlines the participant's health care needs. The Case Manager utilizes this assessment in the development of the participant's plan of care.

The LDSS monitors and oversees the implementation of the service plan through frequent communication with the case managers, through phone contact from the parents/legal guardians, resolution of complaint calls, and through the required, every six month, nursing assessment.

Case Records Maintenance

The original approved and signed Plan of Care is maintained in the applicant's case file by the LDSS CAH I/II coordinator. A copy of the approved Plan of Care is maintained by NYSDOH waiver management staff.

Any subsequent approved revision of a participant's Plan of Care requires the participant's parent(s)/legal guardian's signature. Copies of all Plans of Care are kept in the participant's LDSS case file and are made accessible to NYSDOH as

needed.

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 Case Manager is responsible for the coordination of waiver and non-waiver services. The Case Manager works with the child's physician(s) in setting up the non-waiver services. This is accomplished by conference calls with the physician, parents/legal guardian and state plan service providers.

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 CAH I/II participants are under the age of eighteen and 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 number of hours of skilled care that may be required.

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 and is able to access 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.

The plan of care is reviewed every six months. Physician's orders are updated every 60 days. In the interim, any changes needed in the plan of care to assure the safety of the participant may be brought to the attention of the LDSS by the CAH case manager or any caregiver. The LDSS coordinator 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 case manager when developing the plan of care. Case Managers 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 trained in the care of the child prior to the child's discharge from the hospital or facility. Therefore, in instances when a service cannot be provided, the parents/legal guardians are the backup so that the participant does not go without care. The parents/legal guardians are given the Case Manager's contact information to assist the participant/parent/legal guardian in problem solving as needed.

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 LDSS must offer all applicants/participant's the choice of available services and providers. The LDSS is responsible for making sure that the wavier applicants/participants and their parents/legal guardians know of the participant's right to choose and change service providers, and that the LDSS CAH I/II coordinator will assist the participant in doing so.

The LDSS is also required to provide all applicants/participants with verbal and written notice of their rights under Medicaid.

The LDSS/HRA has the principal role in providing participant choice regarding services and providers. The LDSS/HRA maintains the list of available providers in the county.

The LDSS/HRA provides the participant and or parents/ legal guardians with a list of approved Case Management providers and encourages the parents/ legal guardians interview potential Case Management Agencies. The parents/legal guardians

select the Case Management Agency of their choice and signs and date the Case Management Selection form.

The LDSS/HRA forwards the Case Management Selection form to the selected provider for his/her signature, indicating that s/he are willing and able to accept the applicant's case.

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):

The LDSS CAH I/II coordinator reviews and approves all plans of care. Once the initial plan of care is developed for the applicant, the LDSS makes a determination as to waiver enrollment. The LDSS CAH I/II coordinator then sends the documentation and enrollment recommendation to NYSDOH for review. NYSDOH waiver management staff review the information and notifies the LDSS if they are in agreement with the LDSS's enrollment recommendations. NYSDOH will maintain communication with the LDSS until resolution of any questions or concerns regarding the provision of necessary services to maintain the applicant at home.

NYSDOH waiver management staff are routinely in contact with the LDSS CAH I/II coordinator, case managers, families and providers regarding waiver applicants and services rendered to the waiver participant. NYSDOH waiver management staff monitor plans of care that must include all necessary supporting documentation. If corrective actions are indicated, NYSDOH will notify the LDSS in writing as to the actions necessary to remedy the situation. NYSDOH will also evaluate the documentation from the plans of care against claim data acquired through 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 LDSS CAH I/II coordinator 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 coordinator determines that the proposed or implemented service plan will not meet or is not meeting the needs of the applicant/waiver participant. If the necessary parties (physician, assessing agency, and applicant/parent) cannot agree, the LDSS Medical Professional Director will review case documentation and take action to resolve the situation. NYSDOH waiver management staff provide technical and professional assistance to the LDSS as needed.

NYSDOH waiver staff reviews all initial enrollment packets. This includes Application form, Choice of Care form, proof of age, proof of physical disability, proof of Medicaid eligibility, Level of Care, Home Assessment Abstract, case management selection, MD orders, monthly budget and Plan of Services. Annually, the NYSDOH waiver staff completes record 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 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:

Physician orders every 60 days.

The LOC assessment is conducted annually.

The service plan must be updated at least annually. A plan review occurs every six months. The case manager obtains physician orders for case management and waiver services every 60 days. If physician orders change, the plan of care may be updated or amended prior to the 6 month review period.

- 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:

The LDSS CAH coordinator and the CAH case management agency both maintain participant service plans.

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 and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

In addition to reviewing and approving each plan of care, the LDSS CAH I/II coordinator continually monitors the plan of care and maintains contact with the waiver applicants and their parents/legal guardians, waiver providers and NYSDOH waiver management staff. Identified issues are addressed directly by the LDSS or referred to NYSDOH for review and recommendations. The waiver participant/parents may contact the LDSS CAH I/II coordinator 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.

LDSS/HRA CAH I/II coordinators maintain open communication with all participants and their families. If services are not being provided, the participant/parent/legal guardian contacts the LDSS/HRA CAH I/II coordinators. The case managers are in monthly contact with the participant/parent/legal guardian to assess if services are being provided and back up plans are sufficient. If problems occur, the case manager works with the LDSS/HRA CAH I/II coordinator 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 LDSS and/or NYSDOH waiver management staff. When problems are identified, further investigation is begun by an on-site visit to the LDSS or provider, or through formal referral to the appropriate agency for audit and review.

On a routine basis, NYSDOH waiver management staff monitors the program. 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 agreement. 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 CAH I/II waiver participant. The LDSS is responsible for putting the CAH I/II R/E code and effective date on the participant's WMS file.

Waiver service delivery is also monitored through participant feedback, such as a survey of waiver participants' parents, to gather input about their experiences in the waiver program.

When NYSDOH conducts a random review of all CAH I/II cases, the LDSS 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. If issues are noted by the LDSS CAH I/II coordinator, NYSDOH or another oversight agency, in conjunction with the LDSS, will conduct a case review including service plans, 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 service plan or inconsistent with State and federal regulations, NYSDOH may take steps to terminate the provider's enrollment status.

NYSDOH waiver staff 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, LDSS/HRA quarterly reports, LDSS/HRA quarterly conference calls, case manager calls, and case manager quarterly reports. If trends are noted or problems arise, NYSDOH holds a conference call with the LDSS/HRA CAH I/II coordinator, case manager and participant/family/legal guardian if needed to address the situation or resolve the issue.

- b. Monitoring Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

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 participants' 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 percentage of Plans of Care that address the participants' assessed needs, as noted on the assessment tools, through the provision of waiver and State Plan services or other resources. (Percentage= total number of plans of care that address assessed needs/total number of cases reviewed.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample

		Confidence Interval = 95% confidence interval 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percentage of waiver participant case files that have a case management services form listing the needs identified through assessment and authorized by the physician. (Percentage=total number of case files that have a case management service form that list the participants needs/total number of cases reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

on-site and central desk review

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):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% confidence interval 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. 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 percentage of waiver participant Plans of Care that contain verification of physician orders updated every 60 days, and a participant's parent/legal guardian's signature on the case management services form. (Percentage= Number of plans/case records that contain physician orders and a participant's parent/legal guardian's signature on the plan /total number of case records reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% confidence interval 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: LDSS CAH I/II Coordinator	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percentage of Plans of Care developed in accordance with waiver policy and procedures. (Percentage = Plans of Care that meet requirement/total number of cases reviewed.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: LDSS CAH I/II Coordinator	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: LDSS CAH I/II Coordinator	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

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 percentage of Plans of Care that are updated every six months or when warranted by a change in the participant's needs. (Percentage = number of cases where Plans of care are updated every six months or as needed/total number of cases reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		95% confidence interval 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percentage of waiver participant records that have updated Physician orders every 60 days. (Percentage= number of records where Physician Orders were updated every 60 days /total number of records reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% confidence interval 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

d. **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 percentage of services that are delivered in accordance with the Plan of Care including type of service, amount, scope, duration, and frequency as specified in the authorized plan. (Percentage=total number of records where approved services were delivered according to Plan of Care/total number of records reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% confidence interval 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

e. **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 percentage of participants offered a choice between waiver services and institutional care. (Percentage=Number of participants records that contain Choice of Care form /total number of records reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

on-site and central desk review

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% confidence interval 5% margin of error
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

<input type="text"/>	<input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percentage of waiver participant Plans of Care that have a completed Case Management Selection form in the participant’s case file. (Percentage=total number of records that have signed Case Management Selection forms/total number of records reviewed.)

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 monitors waiver providers that operate in New York State by conducting standard periodic inspections that include State licensure, federal initial certification, and recertification surveys to ensure the agency 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. In addition, provide information on the methods used by the State to document these items.

The remediation process is initiated when the LDSS CAH I/II coordinator or NYSDOH waiver management staff identifies a lack in the quality of provided services, or any other issue related to administration of CAH I/II.

In such situations, the standard procedure is for NYSDOH waiver management staff and the LDSS CAH I/II coordinator to discuss the situation and collaboratively develop a plan of correction. Implementation of and compliance with the plan of correction are monitored by NYSDOH and LDSS staff.

If the plan of correction requires a change in the participant’s service, NYSDOH waiver management staff and the LDSS CAH I/II coordinator will work cooperatively to address the service deficiency and when necessary, transition the child to another CAH I/II provider. To ensure continuity of service during the transition period, the original provider will be required to transfer the CAH I/II 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 CAH I/II services. Accordingly, NYSDOH waiver management staff will issue a letter to the provider terminating the provider’s CAH I/II waiver provider status.

Unsatisfactory home and vehicle modification contractors will be notified of their disqualification from further service by the administering LDSS. The LDSS CAH I/II coordinator will help the family find alternate contractors.

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

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: LDSS CAH I/II Coordinator	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.**
- No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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 CAH I/II 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 includes information to the applicant regarding their general Medicaid rights. Additionally, the Case Manager 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.

Once the application for the CAH program has been reviewed by NYSDOH an acceptance/denial letter is sent to LDSS/HRA staff. Upon receipt of the acceptance/denial letter, the LDSS/HRA issues a Notice of Decision (NOD) to the applicant. A Notice of Decision (NOD) is written documentation from the LDSS/HRA that notifies the applicant/participant of an action taken by the waiver program, including an explanation of the reasons for the action. Notices of Decision (NOD) are issued when an applicant has been approved or denied acceptance into the waiver, or if the participant is being discontinued. Additionally, a NOD is issued if request for services are denied. The LDSS/HRA must give the CAH I/II waiver applicant/participant adequate and timely notice when approving or denying waiver applications and/or when terminating a waiver participant's benefits. The LDSS/HRA sends a written NOD to the participant. Timely and adequate means that the effective date of the adverse action is 10 days after the date the notice was issued. This enables the individual time to exercise fair hearing rights. The Notice of Decision form includes instruction as to how to exercise the right to an agency conference and fair hearing.

In addition to the required notices, the LDSS/HRA CAH Coordinator should exercise due diligence in advising participants about changes in the participant's Plan of Care, providers, available services and method of service delivery. As in all other cases, participants of the waiver can request a Fair Hearing at any time if they feel that the services which they are receiving are not adequate. The LDSS serves as the representing agent for NYSDOH at fair hearings.

Once a NOD is issued, the Case Manager is forwarded a copy by the LDSS/HRA CAH I/II coordinator. The case manager is responsible to ensure the participant/legal guardian understands their his/her right to file a fair hearing within ten days of the decision in order to be eligible for Aid to Continue. "Aid to Continue" means a participant has a right to the continuation of their benefits until the fair hearing process is completed and a decision is rendered. If the request for fair hearing is not completed in the ten days window, the participant/legal guardians have 60 days to request a fair hearing, but will not receive Aid to Continue. Case Managers may assist the participant/legal guardian in filing Fair Hearing requests, collecting any needed documentation. to support the participant's case, and providing factual information to the Administrative Law Judge at the hearing. However, as a Medicaid paid provider, the case manager may not present evidence and/or a position at a fair hearing.

Individuals in receipt of a NOD for issues related to the CAH I/II waiver are eligible for an Informal Conference and/or a Fair Hearing. Fair Hearing requirements set forth in 86 ADM-4 require the LDSS/HRA to provide CAH applicants/participants with timely and adequate Fair Hearing rights when benefits under the waiver are denied, discontinued, or reduced. CAH I/II applicants

and participants have Fair Hearing rights under 18 NYCRR §358-3.1(b)(6).

The Case Manager is also responsible for explaining to the participant that when a fair hearing and Aid to Continue is requested, services remain in place until fair hearing disposition. A copy of the fair hearing information is sent from Office of Temporary Disability Assistance (OTDA), which is responsible for managing and overseeing Fair Hearings for Medicaid issues, to LDSS/HRA and participant

To assure statewide uniformity, NYSDOH has advised the LDSS about CAH I/II fair hearing procedures and related official forms in NYSDOH Administrative Directive 04 OMM\ADM-1.

The regulation for the opportunity for a fair hearing is found in: 18NYCRR 358-3.1

A copy of the NOD and Fair Hearing information is kept in the participant's records maintained by LDSS/HRA and the Case Manager.

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.

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:

- 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).

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.

The New York State Department of Health (NYSDOH) does not have a specific Critical Event or Incident Reporting process for CAH I/II. However, there is a process in place to elicit information on the health and welfare of individuals served through the program and for reporting incidences of abuse, neglect, exploitation, or other concerns.

At a minimum, the CAH I/II case manager must maintain monthly face to face contact with the waiver participant and his or her family. 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 and serve as a vehicle to complete the six month review requirement for the waiver program. During these contacts, possible abuse, neglect, and exploitation may be identified, documented and referred to the appropriate entity for resolution.

CAH I/II waiver participants reside in the community in 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.

- 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:

CAH I/II participants live at home with their parent/legal guardian who have primary legal responsibility for their health and welfare. The LDSS CAH I/II coordinator takes reports about use of restraint or seclusion from parents or other staff. The LDSS Child Protective Services staff investigates and takes any necessary actions. Case managers regularly monitor participant health and welfare during monthly face to face contact.

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:

Any staff person or family member who observes a use of restraint must report it immediately according to agency protocol.

- 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:

CAH I/II participants live at home with their parent/legal guardian who have primary legal responsibility for their health and welfare. The LDSS CAH I/II coordinator takes reports about use of restraint or seclusion from parents or other staff. The LDSS Child Protective Services staff investigates and takes any necessary actions. Case managers regularly monitor participant health and welfare during monthly face to face contact.

- 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.

- 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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

- 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)

- 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. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

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 in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

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 individuals and advocates who were informed of the process to express concerns and objections related to services and quality of care. (Percentage = Number of individuals and advocates who were informed of the process to express concerns, objections, complaints/number of CAH I/II records reviewed)

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
--	---	--

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: LDSS and other NYS responsible entities.	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: LDSS CAH I/II coordinators Other sources	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 incidents reported by the LDSS CAH I/II Coordinator/CAH I/II Case Manager or Mandated Reporter to NYSDOH. (Percentage = number of incidents reported to NYSDOH on a quarterly basis/number of CAH I/II incidents reported annually)

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: LDSS CAH I/II Coordinators and other sources	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: LDSS CAH I/II Coordinators and other sources	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 incidents involving seclusion reported by the LDSS CAH I/II Coordinator/CAH I/II Case Manager or Mandated Reporter to NYSDOH. (Percentage = number of incidents reported to NYSDOH on a quarterly basis/number of CAH I/II incidents reported annually)

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: LDSS	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

		<input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: LDSS	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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:

The number and percentage of CAH I/II service plans (Plan of Care) implemented as written based on verification of service delivery. (Percentage= Number and percent of CAH I/II service plans implemented as written/actual services provided (paid claims).

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

<input type="text"/>	<input type="text"/>
----------------------	----------------------

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 10% of annual enrollment
<input checked="" type="checkbox"/> Other Specify: LDSS CAH I/II Coordinators	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: LDSS CAH I/II Care Coordinators	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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. The protection of waiver participants' health and welfare begins at the local level with the LDSS Child Protective Services Unit (CPS). The New York State Office of Children and Family Services maintains a statewide Central

Register of Child Abuse and Maltreatment for reports made pursuant to New York State Social Services Law. The local CPS Unit is required to investigate reports to protect children from further abuse or maltreatment, and to provide rehabilitative services to children, parents, and other family members.

The CAH I/II case manager contacts the waiver participant's family at a minimum, on a monthly basis. 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.

A physician must review the current medical situation of the participant; this review may reveal necessary changes that must be made to assure the child's continued safety in the community. Orders are completed and renewed every sixty days and whenever there is a change in the child's medical needs. The orders must be signed by the physician, indicating the type, frequency, and duration of skilled home care, treatments and medications and any other necessary services that reflect skilled home care needs.

NYSDOH waiver management staff routinely discuss efforts to prevent abuse, neglect, and exploitation with the LDSS CAH I/II coordinators during quarterly statewide conference calls. The aim is to develop enhanced and consistent statewide incident reporting and documentation processes. NYSDOH/DLTC staff also work with the staff of the LDSS Child Teen Health Program, NYS's federally mandated Early Periodic Screening Program, Diagnosis and Treatment Program, and the Office of Children and Family Services to provide CAH I/II participants and their parents/legal guardians with information about mandated incident reporting policies.

NYSDOH/DLTC also require NYSDOH waiver management staff to be copied on any correspondence that concerns a provider of services for a CAH I/II participant; whether it be a response to a LDSS CAH I/II coordinator, a parent/guardian who has made a complaint, or an investigation of a provider requested by another agency.

Finally NYSDOH waiver management staff performs an annual ten percent case 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 CAH I/II administrative system (including the protocol and performance of the CAH I/II Case manager and LDSS CAH I/II coordinator). These systemic measures have the underlying purpose of preventing abuse, neglect and exploitation of those in the CAH I/II 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. In addition, provide information on the methods used by the State to document these items.

The remediation process is initiated when the LDSS CAH I/II coordinator or NYSDOH waiver management staff identify a lack in the quality of provided services, or any other issue related to administration of CAH I/II.

In such situations, the standard procedure is for NYSDOH waiver management staff and the LDSS CAH I/II coordinator to discuss the situation and collaboratively develop a plan of corrective action. Implementation and compliance with the plan of correction is monitored by NYSDOH and LDSS staff.

Should the plan of correction require a change in the participant's service, NYSDOH waiver management staff and the LDSS CAH I/II coordinator will work cooperatively to address the service deficiency and when necessary, transition the child to another CAH I/II provider. To ensure continuity of service during the transition period, the original provider will be required to transfer the CAH I/II participant case records and other pertinent documents to the new provider in a timely manner.

Remediation of financial issues begins immediately upon the discovery of any impropriety. The NYSDOH waiver management staff, and other Department staff as appropriate, will immediately initiate remediation of any inappropriate claims processed through eMedNY. Remediation may include voiding payments, assigning penalties, and sanctioning providers. In the case of home and vehicle modifications, LDSS staff will initiate remediation by cancelling payments to home and vehicle contractors. The LDSS staff will initiate remediation of any inappropriate claims processed on Schedule E.

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 CAH I/II services. Accordingly, NYSDOH waiver management staff will issue a letter to the provider terminating the provider’s CAH I/II waiver provider status.

Unsatisfactory home and vehicle modification contractors will be notified of their disqualification from further service by the administering LDSS. The LDSS CAH I/II coordinator will help the family find alternate contractors.

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: As needed

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 2)

Under §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 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;
- 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 Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, 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 Quality Improvement Strategy 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 Quality Improvement Strategy. 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 2)

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 location of NYSDOH long term care (LTC) functions within the Office of the State Medicaid Director provides advantages for QA/QI activities. All of the State's 1915(c) waivers managed by the agency and serving the long term care needs of Medicaid consumers (Traumatic Brain Injury, Nursing Home Transition Diversion, Care at Home) are under the management of the Director of the Division of Long Term Care. This facilitates cross waiver analysis, policy development and systems change, and a comparison of identified problems, solutions, and best policies. It also permits better integration of QA/QI waiver initiatives with those pursued for State Plan long term care services. For example, the Department's initiative to develop a uniform assessment system will result in the ability to perform analysis and service improvement activities for all of the waivers as well as Medicaid State Plan and 1915(c) services.

Typically, NYSDOH/DLTC 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 LDSS CAH I/II coordinators, and direct communication with NYSDOH waiver management staff. If an investigation 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, waiver participants, providers and other stakeholders are considered.

Position papers summarizing the findings and analysis are presented to senior NYSDOH managers. Recommendations are prioritized by DLTC Executive staff in consultation with the State Medicaid Director 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 through the established annual NYS budget and legislative process. At this stage, DLTC staff 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/DLTC staff implement system change when authorized by NYSDOH and the Medicaid Director.

ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input checked="" type="checkbox"/> Other Specify: LDSS CAH I/II Coordinators	<input type="checkbox"/> Other Specify: <input type="text"/>

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.

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 CAH I/II waiver program by asking for the input of those who use the waiver's services. The LDSS and NYSDOH/DLTC 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.

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).

CAH I & II HCBS services 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.

NYSDOH is the single State agency responsible for monitoring payments made under the New York State Medicaid program.

Statewide audits of Medicaid funded programs are conducted by the office of 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. In addition, the operating agency and local counties also conduct reviews and audits of Medicaid funded programs.

Annual Cost Reporting and Auditing

Cost reporting for non-profit waiver services will be subject to review. Should the waiver not transition to managed care effective January 1, 2018, NYSDOH will seek an amendment to the waiver implementing cost reporting using the CMS agreed-upon format. The Cost report will be submitted to CMS within 16 months after the close of the reporting period.

Delinquent Cost Reporting for Non-State Providers

If a provider has not filed a complete and compliant annual Consolidated Fiscal Report (CFR) for any CFR reporting period, the Provider will be considered delinquent. The State will not claim FFP for any Waiver Services provided by a delinquent provider.

For CFR cost reporting beginning January 1, 2018 and thereafter, NS providers are required to file an annual CFR to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period. If a NS provider fails to file a complete and compliant CFR within 60 days following the imposition of the 2% penalty, the State must provide timely notice to the delinquent provider that FFP will end 240 days following the imposition of the 2% penalty; and the State will not claim FFP for any waiver services provided by the NS provider with a date of service after the 240 day period.

Oversight of Service Delivery and Billings and Claims:

Each waiver year, NYSDOH will establish an audit pool that includes all waiver service providers with waiver service billings. Paid claims will be audited to ensure that providers are appropriately billing for authorized services, correct reimbursement rates/fees, and for the correct number of units of service. NYSDOH conducts an annual review of less than 100% of records of individuals actively enrolled in CAH I/II waiver services at the time of audit using a statistically reliable sample with a 95% confidence interval and a 5% margin of error using Raosoft formulas.

The sample is garnered from paid claims data presented in eMedNY. In conjunction with this review, paid claims will be cross referenced to Care Plans to ensure billing is consistent with services in the approved plan. Audit protocols are applied to a specific provider type or category of service in the course of an audit. Audit protocols are used as a guide in the course of an audit to evaluate a provider's compliance with Medicaid requirements and to determine the propriety of Medicaid expended funds. Effective for dates of service beginning with the approval of the waiver, all waiver providers are subject to audits.

Any systemic deficiencies will be identified and a plan of correction developed which may result in the following: 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 reimbursed to the state and FFP will be returned to CMS. Annual audits of claims shall be completed with 12 months following the end of the waiver year.

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. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

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 in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

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:

Audits of claiming and billing will be annual. Number and percent of claims for waiver services adjudicated through eMedNY that can be identified as billed by an enrolled waiver provider, and provided to an active waiver participant at the time of service delivery. (Percentage = number of paid claims for verified waiver participants and providers/total number of claims reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and central desk review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% confidence interval 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% sample
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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:

Year-end cost reports submitted using the correct format and submitted in a timely manner. (Percentage= percentage of cost reports received using the correct format and submitted within required time frames/ the total number of approved providers submitting claims for services)

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

	Sampling Approach (check each that applies):
--	---

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

The remediation process is initiated when the LDSS CAH I/II coordinator or NYSDOH waiver management staff identifies a lack in the quality of provided services, or any other significant issue related to administration of CAH I/II.

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, as appropriate, immediately initiate remediation of any inappropriate claims processed through eMedNY. 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 CAH I/II services. In such circumstances, NYSDOH waiver management staff will issue a letter to the provider terminating the provider’s CAH I/II waiver provider status.

For Home and Vehicle modifications, the Local Department of Social Services (LDSS) claims these costs on the standard Schedule E for reimbursement from the State. The Welfare Management System (WMS) is a mechanism for counties to report Medicaid expenditures to NYSDOH. Expenditures for participants in the CAH Program are claimed on line 23 of the Schedule E. 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 LDSS and NYSDOH monitor this data. NYSDOH will advise the LDSS of any inappropriate claims and the LDSS staff will initiate remediation of the incorrect claim(s).

An Unsatisfactory home and vehicle modification contractors will be notified that the contractor will be disqualified from further service by the administering LDSS. The LDSS CAH I/II coordinator along with the child’s case manager will then help any family that has received or was expecting to receive services from that contractor to find a new contractor.

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

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

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 CAH I/II waiver will transition to managed care under the 1115 Demonstration effective January 1, 2018. Should the transition be delayed, NYSDOH will amend the application to reflect financial and program requirements. This fee schedule expense reimbursement covers claims effective for dates of service beginning with the approval of the waiver through 12/31/2017. This fee-schedule will sunset on 12/31/2017.

Provider Reimbursement of Waiver Services

CAH I & II HCBS services 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) renewal application seeks to renew the 1915(c) Home and Community Based Medicaid (MA) waiver, Care at Home I/II (CAH I/II), to extend it effective the approval date of the waiver through December 31, 2017; after which, the waiver will transition into managed care via the 1115 authority on January 1, 2018. Should the waiver not transition to managed care effective January 1, 2018, NYSDOH will seek an amendment to the waiver implementing cost reporting using the CMS agreed-upon format. The Cost report will be submitted to CMS within 16 months after the close of the reporting period.

The Waiver services include: Case Management, Family Palliative Care Education (Training), Bereavement Services, Massage Therapy, Expressive Therapies , Home and Vehicle Modifications.

I. Definitions Applicable to this Section

- a. Consolidated Cost Report: The CFR is the report and associated instructions utilized by all government and non-government providers to communicate annual costs incurred as a result of operating CAH I, and CAH II programs and services, along with related patient utilization and staffing statistics.
- b. Rate: A reimbursement amount based on a computation using annual provider reimbursable cost divided by the applicable annual units of service.
- c. Units of Service: The unit of measure varies by the type of service, i.e., 15 min., 30 min. or one-time occurrence.

The unit of measure used for the following waiver services are:

- Case Management: 15 minutes

- Family Palliative Care Education (Training): 30 minutes
- Bereavement Services: 30 minutes
- Massage Therapy: 30 Minutes
- Expressive Therapy: 30 minutes
- Home and Vehicle Modifications: one time occurrence

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 Cost Reporting schedules to be completed annually are:

CCR-i - Agency Identification and Certification Statement
 CCR-ii/CFR-ia - Independent Accountant's Report
 CCR-1 - Program/Site Data
 CCR-2 - Agency Fiscal Summary
 CCR-3 - Agency Administration
 CCR-4 - CFR 4 A – Contracted Direct Care and Clinical Personal Services Personal Services

III. Services Paid via Fee Schedule: Statewide Rates for All providers

1. Case Management	\$22.73	15 min
2. Family Palliative Care Education (Training)	\$40.00	30 min
3. Bereavement Services	\$40.00	30 min
4. Massage Therapy	\$40.00	30 min
5. Expressive Therapies	\$40.00	30 min
6. Home & Vehicle Modifications (one-time maximum, every 5 years)	Home	Vehicle
	\$25,000	\$25,000

Cost reporting for non-profit waiver services will be subject to review. Should the waiver not transition to managed care effective January 1, 2018, NYSDOH will seek an amendment to the waiver implementing cost reporting using the CMS agreed-upon format. The Cost report will be submitted to CMS within 16 months after the close of the reporting period. The use of retrospective reimbursement, using service provider cost requires a reconciliation of any and all interim payments to the final allowable Medicaid cost for each rate year. FFP would be limited to the actual cost of the service(s) at the service provider level, or if reimbursement payments to the service provider were less and/or ultimately less than actual cost, FFP would be limited to the lower of these to actual cost or actual payments. If such total payments for any Waiver Service, subject to the annual reconciliation, exceed the final allowable Medicaid reimbursement for such rate period, the State will treat any overage as an overpayment of the federal share, and any overpayment shall be returned to CMS on the next calendar quarter CMS-64 expenditure report. If the total payments for a Waiver Service, subject to annual reconciliation, are less than the allowable Medicaid reimbursement for such rate period, the State shall be entitled to submit a claim for the federal share of such difference.

IV. Services paid using a Contract Amount

- a. Home & Vehicle Modifications
 - i. The LDSS is the provider of record for Home & Vehicle Modifications for billing purposes. The work is done by a contractor who is selected by a standard bidding process, following the rules of the OSC. Home & Vehicle Modifications is 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 maximum expenditure for Home & Vehicle Modifications for the benefit of the individual Medicaid beneficiary may not exceed \$25,000 for home and \$25,000 for vehicle modifications per five year period. If the person requires an expenditure which exceeds the maximum expenditure amount, the Single State Medicaid Agency may submit and seek approval of an amendment to the waiver; the Single State Agency shall provide supporting documentation as deemed necessary by CMS to support approval of the amendment.

V. Trend Factors

- a. The trend factor used 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.

These cost reports will be used to reconcile the Medicaid payments for waivers.

If parents/guardians of CAH I/II participants have any questions about the payment rates made to the agencies CAH I&II providers, they may contact the LDSS, their case manager or the DOH Public Affairs Office to obtain this information.

- 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:

Billings flow directly from the provider to New York State's MMIS (eMedNY).

1) Case Management, Bereavement Services, Expressive Therapies, Family Palliative Care Education (Training) and Massage Therapy are reimbursed through a statewide fee rate schedule,

2) Home and vehicle modifications do not result in a claim to eMedNY because such projects are contracted. Instead, NYS utilizes a vendor bid process for home and vehicle modifications; and payments are made to the provider by the LDSS. The LDSS in turn, bills the NYSDOH using the established District Claiming Procedures (Schedule E). See Appendix I-3 g-I for voluntary reassignment of payments for additional information.

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:

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 billings are processed either through eMedNY or through direct payment to the vendor by the County/LDSS for home and vehicle modifications and will be subjected to eligibility and payment edits.

Case Management, Bereavement Services, Expressive Therapies, Massage Therapies, Family Palliative Care Education (Training) are adjudicated through eMedNY, CAH I/II participants' eligibility for the waiver services on the date of the claim is verified through the payment system edits. Home & Vehicle Modification services, the responsible LDSS verifies: participants' eligibility for the service services on the date of the claim, date of service delivery, plan of care identification as authorized service and physician order for the Home & Vehicle Modification project as medically necessary.

Prior to the final payment for Home & Vehicle Modifications, the LDSS staff, contractor or/and case 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 file and a copy is forwarded to NYSDOH waiver management staff.

- 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:

For home and vehicle modifications paid under Schedule E, the LDSS verifies the child's eligibility and makes a partial payment to the contractor at outset of the project. The LDSS 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. LDSS reports these expenditures on Schedule E in accordance with the NYS Fiscal Reference Manual. Schedule E has a dedicated line, line 20, which the LDSS uses to report CAH home and vehicle modification waiver expenditures. The LDSS also authorizes these expenditures in the Welfare Management System (WMS) with a pay type of P9 and special claiming categories of V for federally participating, R for federally non-participating, and N for Non-Reimbursable. These expenditures are then entered in the State's Automated Claims System which is used to generate the quarterly CMS-64 report. Data to support the Schedule E claim is maintained at the LDSS for annual DOH review and audit purposes. In addition, home and vehicle modifications are reviewed as part of the NYSDOH annual sample review of cases.

- 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.

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:

Home and Vehicle Modifications

The LDSS is the provider of record for Home and Vehicle Modifications. The term provider of records indicates that the LDSS contracts with another entity for the provision of services. There are no State or local government providers approved to provide Home & Vehicle Modification services.

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.

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.

Home and Vehicle modification is the only CAH I/II service for which payments are reassigned. Vendors are required to sign a Statement of Reassignment that they will only bill the LDSS 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 LDSS 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 00 OMM/ADM-4.

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:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- 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) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §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 §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 §1915(b)/§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 §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 1115/1915(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 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

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:

For services delivered by provider agencies, 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 CAH I/II claims. The federal share of CAH funds is drawn down based on State Share claims. Such claims are adjudicated through e-MedNY.

New York State certifies that no federal funds are incorporated into the funds used to make up the State share.

- 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:

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. 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.

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:

Do not complete this item.

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

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	9430.00	203764.05	213194.05	139580.07	136044.80	275624.87	62430.82
2	9629.00	212471.19	222100.19	145559.13	141749.19	287308.32	65208.13
3	9482.48	221557.99	231040.47	151799.45	147698.24	299497.69	68457.22
4	7599.24		238640.53			312215.27	73574.74

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)
		231041.29		158312.63	153902.64		
5	9416.00	240938.69	250354.69	165110.80	160373.58	325484.38	75129.69

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:	Level of Care:
		Hospital	Nursing Facility
Year 1	1600	256	1344
Year 2	1755	281	1474
Year 3	2053	328	1725
Year 4	2402	384	2018
Year 5	2810	450	2360

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.

The average length of stay is calculated by applying the trend factor for enrollment growth of all new unduplicated recipients based on prior 372 reports. That amount is added to the unduplicated count of recipients at the previous each waiver year. That total is divided by the total unduplicated recipient count, and then multiplied by the annual days in the waiver year.

If the waiver does not end on December 31, 2017, the State will submit a Corrective Action Plan to address deficiencies with the underlining data used in Appendix J.

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 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.

In the instance of the palliative care services, while use in the current waiver period has been minimal, for the renewal period the projected use (2.5% of participants) reflects an assumption of increased awareness of the benefit and increased availability of palliative care for children approaching the end of life.

- 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:

Factor D' values are derived from the eMedNY data for waiver period 12/1/10 - 11/30/11, and the 372 report for that period as approved by CMS. This report includes all MA State Plan service costs, including any institutional or other care received by CAH I/II waiver participants. For the waiver renewal years, the 2010-11 values were trended forward using NYS authorized trend factors for nursing home and hospital costs, 3.4% and 4.7% respectively.

- 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 nursing home and hospital care of child Medicaid recipients of the same age who have comparable disabilities to CAH I/II participants for dates of service during the 2010-11 waiver year. This information is generated from the eMedNY, AFPP Data Mart Claims system. [See Appendix I-1 for description of the eMedNY system.]

- 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 2010-11 waiver year. This information is generated from the eMedNY AFPP Data Mart Claims system.

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	
Case Management	
Bereavement Services	
Expressive Therapies	
Family Palliative Care Education (Training)	
Home and Vehicle Modification	
Massage Therapy	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** 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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						8728320.00
Case Management	Hour	1600	60.00	90.92	8728320.00	
Bereavement Services Total:						
GRAND TOTAL:						15088320.00
Total Estimated Unduplicated Participants:						1600
Factor D (Divide total by number of participants):						9430.00
Average Length of Stay on the Waiver:						309

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						480000.00
Bereavement Services	Hour	100	120.00	40.00	480000.00	
Expressive Therapies Total:						240000.00
Expressive Therapies	Hour	100	60.00	40.00	240000.00	
Family Palliative Care Education (Training) Total:						400000.00
Family Palliative Care Education (Training)	Hour	100	100.00	40.00	400000.00	
Home and Vehicle Modification Total:						5000000.00
Home and Vehicle Modification	Project	200	1.00	25000.00	5000000.00	
Massage Therapy Total:						240000.00
Massage Therapy	Hour	100	60.00	40.00	240000.00	
GRAND TOTAL:						15088320.00
Total Estimated Unduplicated Participants:						1600
Factor D (Divide total by number of participants):						9430.00
Average Length of Stay on the Waiver:						309

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. 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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						9573876.00
Case Management	Hour	1755	60.00	90.92	9573876.00	
Bereavement Services Total:						600000.00
Bereavement Services	Hour	125	120.00	40.00	600000.00	
Expressive Therapies Total:						300000.00
Expressive Therapies	Hour		60.00	40.00	300000.00	
GRAND TOTAL:						16898876.00
Total Estimated Unduplicated Participants:						1755
Factor D (Divide total by number of participants):						9629.00
Average Length of Stay on the Waiver:						309

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		125				
Family Palliative Care Education (Training) Total:						500000.00
Family Palliative Care Education (Training)	Hour	125	100.00	40.00	500000.00	
Home and Vehicle Modification Total:						5625000.00
Home and Vehicle Modification	Project	225	1.00	25000.00	5625000.00	
Message Therapy Total:						300000.00
Message Therapy	Hour	125	60.00	40.00	300000.00	
GRAND TOTAL:						1689876.00
Total Estimated Unduplicated Participants:						1755
Factor D (Divide total by number of participants):						9629.00
Average Length of Stay on the Waiver:						309

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. 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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						11199525.60
Case Management	Hour	2053	60.00	90.92	11199525.60	
Bereavement Services Total:						624000.00
Bereavement Services	Hour	130	120.00	40.00	624000.00	
Expressive Therapies Total:						312000.00
Expressive Therapies	Hour	130	60.00	40.00	312000.00	
Family Palliative Care Education (Training) Total:						520000.00
Family Palliative Care Education (Training)	Hour	130	100.00	40.00	520000.00	
Home and Vehicle Modification Total:						6500000.00
GRAND TOTAL:						19467525.60
Total Estimated Unduplicated Participants:						2053
Factor D (Divide total by number of participants):						9482.48
Average Length of Stay on the Waiver:						309

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home and Vehicle Modification	Project	260	1.00	25000.00	6500000.00	
Message Therapy Total:						312000.00
Message Therapy	Hour	130	60.00	40.00	312000.00	
GRAND TOTAL:						19467525.60
Total Estimated Unduplicated Participants:						2053
Factor D (Divide total by number of participants):						9482.48
Average Length of Stay on the Waiver:						309

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. 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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						12613382.40
Case Management	Hour	2402	60.00	87.52	12613382.40	
Bereavement Services Total:						720000.00
Bereavement Services	Hour	150	120.00	40.00	720000.00	
Expressive Therapies Total:						360000.00
Expressive Therapies	Hour	150	60.00	40.00	360000.00	
Family Palliative Care Education (Training) Total:						600000.00
Family Palliative Care Education (Training)	Hour	150	100.00	40.00	600000.00	
Home and Vehicle Modification Total:						3600000.00
Home and Vehicle Modification	Project	300	1.00	12000.00	3600000.00	
Message Therapy Total:						360000.00
Message Therapy	Hour	150	60.00	40.00	360000.00	
GRAND TOTAL:						18253382.40
Total Estimated Unduplicated Participants:						2402
Factor D (Divide total by number of participants):						7599.24
Average Length of Stay on the Waiver:						309

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (9 of 9)****d. Estimate of Factor D.**

i. Non-Concurrent Waiver. 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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						15329112.00
Case Management	Hour	2810	60.00	90.92	15329112.00	
Bereavement Services Total:						840000.00
Bereavement Services	Hour	175	120.00	40.00	840000.00	
Expressive Therapies Total:						420000.00
Expressive Therapies	Hour	175	60.00	40.00	420000.00	
Family Palliative Care Education (Training) Total:						700000.00
Family Palliative Care Education (Training)	Hour	175	100.00	40.00	700000.00	
Home and Vehicle Modification Total:						8750000.00
Home and Vehicle Modification	Project	350	1.00	25000.00	8750000.00	
Massage Therapy Total:						420000.00
Massage Therapy	Hour	175	60.00	40.00	420000.00	