

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:

1. Elimination of Spousal Impoverishment post eligibility budgeting rules for waiver participants. This change to the current waiver will be accomplished through an amendment to Section 366-c of the New York State Social Service Law. It is not possible to have this change enacted prior to the March 31, 2008 termination date of the current TBI waiver as it will occur as part of the SFY 2008-2009 budget. The earliest possible date for approval of the legislation is April 1, 2008. As advised by CMS, DOH has submitted a request for a ninety (90) day extension of the current waiver to allow time for the legislative action to be enacted.
2. For waiver services: Service Coordinator, Community Integration Counselor(CIC), Independent Living Skills Training (ILST), Positive Behavioral Interventions and Supports (PBIS), the Director for Structor Day Program and the Director for a Substance Abuse Program, the qualifications for individual providers has been revised to include individuals with a Doctorate in Psychology. This is anticipated to help increase the number of available providers for these services.
3. Minimum qualifications for staff employed by a Structured Day Program have been defined. Previously, only qualifications for the Director of the program were defined.
4. Intensive Behavioral Program (IBP) has been changed to Positive Behavioral Interventions and Support Services (PBIS). This reflects the name for the same service used by NHTD and represents a more positive title for the service.

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*):
TBI waiver renewal
- C. **Type of Request:** renewal
 - Migration Waiver** - this is an existing approved waiver
 - Renewal of Waiver:**
Provide the information about the original waiver being renewed
Base Waiver Number:

Amendment Number

(if applicable):

Effective Date: (mm/dd/yy)

04/01/03

Waiver Number: NY.0269.R01.00**Draft ID:** NY.07.01.00**Renewal Number:** 01**D. Type of Waiver** (select only one):Regular Waiver **E. Proposed Effective Date:** (mm/dd/yy)

04/01/08

Approved Effective Date: 06/30/08**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 the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR 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) 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 authorized under §1115 of the Act.

Specify the program:

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 Traumatic Brain Injury (TBI) Medicaid Waiver will provide community-based alternatives to individuals with TBI who are between the ages of 18 and 64 years old at the time of admission, and eligible for nursing facility placement. The TBI waiver will allow waiver participants to avoid or transition from unwanted nursing home placement.

Designed to promote waiver participant choice, TBI waiver participants will choose:

- (1) to receive TBI services instead of nursing home services;
- (2) to receive TBI services instead of other Home and Community-Based Services (HCBS) Medicaid Waiver services for which they may be eligible;
- (3) their service providers; and
- (4) what services to receive as part of service plan development,

Over the next five (5) years, this application is requesting to serve at least 1,500 additional individuals. .

The New York State Department of Health (NYSDOH), Office of Long Term Care, Bureau of Medicaid Long Term Care is responsible for the operation and oversight of the TBI waiver. NYSDOH is designated as the single State agency responsible for the administration of the Medicaid program. Deborah Bachrach, Deputy Commissioner of the Office of Health Insurance Programs (OHIP), is the Director of the Medicaid Program and, in that capacity, is the signatory to the TBI waiver application. Mark Kissinger is the Deputy Commissioner of the Office of Long Term Care (OLTC) responsible for policy and administration of long term care programs. The TBI waiver is an important element of the State's effort to restructure its long term care system. Therefore, these two offices collaborate on the administration of the TBI Waiver Program; however Ms. Bachrach, as the State Medicaid Director, has final authority with regard to administration of all aspects of the Medicaid program in New York State, including its waiver programs.

In order to promote efficiency and allow for regional flexibility, DOH will contract with not-for-profit agencies in ten (10) regions across the state with demonstrated experience providing community-based services to individuals with TBI. These agencies will serve as Regional Resource Development Centers (RRDCs) and employ Regional Resource Development Specialists (RRDSs). The RRDCs will be responsible for determining waiver participant eligibility, reviewing Service Plans, meeting regional aggregate budgeting targets, organizing local outreach efforts, developing regional resources, making recommendations to DOH Waiver Management Staff about enrolling waiver services providers, and training service providers.

An essential component of the TBI waiver is the waiver participant's right to choose a service provider, especially his/her Service Coordinator. At the regional level, RRDSs will be responsible for providing unbiased and comprehensive information to enable potential waiver participants to make informed decisions about whom to choose as a Service Coordinator. The Service Coordinator is crucial to the waiver participants' success in the community, as they work with the waiver participant in the development, implementation, and evaluation of the Service Plan. The Service Coordinator is responsible for assuring the waiver participant's choice of other providers. The TBI waiver will be administered via the provider managed method.

In order to assure implementation of its Quality Management Program, DOH will contract with a Clinical Consultant. The Clinical Consultant will work closely with DOH Waiver Management Staff to implement a quality management program, act as a liaison between DOH Waiver Management Staff, RRDCs and service providers, review Service Plans with a budget over an amount determined by DOH, and provide technical assistance to the RRDSs.

DOH Waiver Management Staff, the the Clinical Consultant and/or DOH survey team staff will monitor the RRDCs by conducting on-site visits and annual evaluations to assure they are meeting their contractual obligations.

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 Management Strategy. Appendix H** contains the Quality Management 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/MR.
- 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 Management.** 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 Management Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
The development of the TBI waiver is authorized by the Public Health Law of New York which delegates the responsibility to the Department of Health to administer the TBI Program and outlines the powers and duties of the Department. This legislation also created the TBI Coordinating Counsel as an advisory group to the waiver and indicates the members of this counsel. This counsel is comprised of representative from various entities that include but are not limited to: individuals with TBI, advocates, community based service providers, NYS Public Welfare Association members and state and local governments throughout New York State.
- 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:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

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

Last Name:

First Name:	<input type="text"/>
Title:	<input type="text"/>
Agency:	<input type="text"/>
Address:	<input type="text"/>
Address 2:	<input type="text"/>
City:	<input type="text"/>
State:	New York
Zip:	<input type="text"/>
Phone:	<input type="text"/> Ext: <input type="text"/> <input type="checkbox"/> TTY
Fax:	<input type="text"/>
E-mail:	<input type="text"/>

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:	<input type="text" value="Deborah Bachrach"/> State Medicaid Director or Designee
Submission Date:	<input type="text" value="May 30, 2008"/>

Last Name:	<input type="text" value="Bachrach"/>
First Name:	<input type="text" value="Deborah S."/>
Title:	<input type="text" value="Deputy Commissioner, Office of Health Insurance Programs"/>
Agency:	<input type="text" value="New York Department of Health"/>
Address:	<input type="text" value="Corning Tower, Empire State Plaza"/>
Address 2:	<input type="text"/>
City:	<input type="text" value="Albany"/>
State:	New York
Zip:	<input type="text" value="12237"/>
Phone:	<input type="text" value="(518) 474-3018"/>
Fax:	<input type="text" value="(518) 486-6852"/>
E-mail:	<input type="text" value="dsb10@health.state.ny.us"/>

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

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: do not complete Item A-2*):

- The Medical Assistance Unit.**

Specify the unit name:

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

Specify the unit name:

Office of Long Term Care.

Do not complete item A-2.

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

Specify the 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.*

Appendix A: Waiver Administration and Operation

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, 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.:*

Contracted entities (Regional Resource Development Centers - RRDCs) perform waiver operational and administrative functions on behalf of the Medicaid agency and/or waiver operating agency. The State contracts

with 10 not-for-profit agencies across the State, each responsible for regional areas which include multiple counties. In order to prevent any conflict of interest, RRDCs are not permitted to be waiver service providers.

RRDCs contract responsibilities for operation and administration of the waiver include:

Disseminate information concerning the waiver to community agencies, families and potential waiver participants through meetings, telephone calls, referrals, community contacts and written information.

Assist with waiver enrollment - RRDC staff meet with each potential waiver participants to discuss waiver services and philosophy, explain participants rights and make preliminary determinations of eligibility for participation in the waiver. They inform individuals of their freedom to choose the waiver versus institutionalization and informs them of their rights. Those choosing to apply for the waiver receive a list of approved Service Coordination agencies who will assist the individual to select needed services and develop a service plan.

Monitor waiver expenditures - RRDC staff review all service plans to ensure cost effectiveness and track aggregate costs to ensure cost neutrality within their region

Review participant service plans - RRDC staff review and prior approve of all initial service plans and revised service plans every six months. They review plans to ensure the health and welfare of the participant, cost effectiveness, optimum level of independence, effective use of services and participant choice.

Provider recruitment - RRDC staff assess the need for services in their regions and conduct outreach to recruit providers or assist current providers to expand their scope of waiver services when appropriate. They interviews potential providers and make recommendations to DOH on whether to enroll the provider based on regional factors of need or the agency's ability to deliver high quality, cost effective services to the TBI population.

Conduct training and technical assistance - RRDC staff provide technical assistance to providers, participants, advocates, community services and other RRDCs. Each conducts provider training at least 10 times a year.

- 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:

- 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 single State Agency responsible for assessing the performance of non-state entities that conduct waiver operational and administrative functions is the DOH, Office of Long Term Care (OLTC), Bureau of Medicaid Long Term Care (BMLTC).

Appendix A: Waiver Administration and Operation

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

DOH-BMLTC contracts with not-for-profit entities in ten (10) regions across the state with demonstrated experience in conducting waiver operational functions and activities. These agencies serve as Regional Resource Development Centers (RRDCs) and employ Regional Resource Development Specialists (RRDSs). The State assesses these RRDCs for their performance of waiver functions which they are responsible for on an ongoing regular basis, using divergent methods. These methods and frequency of their use is specified below.

The RRDSs are responsible for the development, management, monitoring & administration of the HCBS/TBI waiver program for the RRDCs on a regional level. The RRDSs are responsible for the review of Service Plans, including initial and revised service plans, as well as addendums to service plans. Service Plans specifically state the amount & frequency of each required waiver service offered to a participant.

In addition, DOH-BMLTC contracts with a Clinical Consultant (CC) function to conduct oversight & quality assurance activities. The RRDSs assist the CC with review of the Incident Reporting Forms upon request of the CC, & the CC consults with the RRDS in determining whether an investigation should be deemed closed or open for further investigation.

DOH Waiver Mgmt Staff will require quarterly reports from the RRDCs and the CC, & develop a database to evaluate trends. DOH Waiver Mgmt Staff & the CC will conduct retrospective annual reviews of a random sample of Service Plans along with targeted reviews of all plans costing an amount established by DOH. DOH Waiver Management Staff will meet with the RRDS & the CC on a quarterly basis. There will be annual on-site visits, for review of operational and administrative performance, along with retrospective reviews of a random sample of Service Plans to assure quality performance of these entities. In addition, DOH Waiver Mgmt Staff will have regular telephone calls with the RRDSs, which will provide DOH Waiver Mgmt Staff with information regarding the RRDS' functioning. It is expected that DOH Waiver Mgmt Staff will also receive calls from the waiver participant, family members, advocates, waiver service providers, Local Departments of Social Services & CC, which will also contribute to DOH Waiver Mgmt Staff's assessment of the RRDS.

In addition to reviewing Service Plans costing over an amount established by DOH, the CC's review includes the justification of services, compliance with Medicaid & waiver regulations, as well as quality of life issues for the participant. Each Plan is reviewed with the participant's optimal level of independence in mind. Suggestions are made, when appropriate, for decreasing dependency on staffing & program services such as: a cohesive & positive team approach to challenges, and/or the possible use of assistive technology to augment Service Plans to increase independence.

The State has established a toll-free hotline specific to TBI waiver participants, their families & advocates for registering complaints & concerns. This includes a regular reporting & tracking process to describe types of calls received, the providers & the regions involved. Every TBI participant is provided with a magnet. It can be posted on their kitchen appliances for quick retrieval, which contains the hotline number & website address.

TBI management staff presents a workshop & listening forum at the BIANYS' and TBI's annual conferences in June & October, respectively.

DOH also contracts with a Neurobehavioral Resource Project for review of all intensive behavior plans statewide &

consultation, training & technical assistance to assure that persons with challenging behaviors are able to live in the community appropriately with safety & satisfaction. Otherwise, recommendations are made for placement in a more appropriate structured setting.

All prospective providers are interviewed by the RRDSs in the region(s) they request to serve. The RRDS(s) recommendation(s), in conjunction with the required interview documentation, is provided to TBI waiver mgmt staff for final approval based on a due diligence process. Enrolled providers are responsible for developing & utilizing self-monitoring tools & a consumer satisfaction survey. Each provider is required to maintain the necessary records to substantiate the provision of services & evaluate the effectiveness of each service.

DOH-HCBS/TBI waiver program staff works closely with the Office of Long Term Care surveillance staff to support their efforts with on-site surveys for a sample of providers. During the review period, prior to this application, the professional review organization surveyed 33 provider agencies as part of the quality assurance process. Using experience from these initial surveys, DOH staff is working to refine the surveillance process & has recently hired additional staff to increase surveillance activities.

****RAI: DOH surveys IBP provider at least once every 3 years. Provider survey results are used to identify patterns of deficiencies across providers which may require additional technical assistance. Waiver Mgmt Staff & the Neurobehavioral Project (NP) are available to provide intensive technical assistance to the problematic providers within each RRDC region. This would include further review of participant behavioral plans as well as participant interviews. Individual participant case records & behavioral plans may be reviewed at the discretion of DOH TBI Waiver Mgmt Staff, RRDSs & NP at any time. RRDSs review IBPs every six months. RRDSs may consult with the CC & NP to obtain additional clinical opinions & guidance. NP recently completed an extensive review of all IBPs statewide to identify key areas for improvement (see Book I, Neurobehavioral Resource Project tab). NP & RRDSs are working in conjunction to identify & integrate best practices for IBPs into standard practice.

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.

Function	Medicaid Agency	Contracted Entity
Disseminate information concerning the waiver to potential enrollees	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Assist individuals in waiver enrollment	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Manage waiver enrollment against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Monitor waiver expenditures against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Conduct level of care evaluation activities	<input type="checkbox"/>	<input type="checkbox"/>
Review participant service plans to ensure that waiver requirements are met	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Perform prior authorization of waiver services	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Conduct utilization management functions	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Recruit providers	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Execute the Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Determine waiver payment amounts or rates	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Conduct training and technical assistance concerning waiver requirements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix B: Participant Access and Eligibility

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

- a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group

or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input checked="" type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input checked="" type="checkbox"/>	Brain Injury	18	<input type="text"/>	<input checked="" type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Mental Retardation or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Mental Retardation	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	

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

Individuals with a traumatic brain injury with structural non-degenerative brain damage as the primary diagnosis are eligible for the waiver. In addition, a limited number of individuals with anoxia, toxic poisoning, encephalitis, and other neurological conditions which result in conditions similar to a traumatic brain injury will also be served. Individuals with gestational or birth difficulties such as cerebral palsy or autism or who have a progressive degenerative disease, are not eligible for the waiver.

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:

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*):

- 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	2739
Year 2	3039
Year 3	3339
Year 4 (renewal only)	3639
Year 5 (renewal only)	3939

- 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	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4 (renewal only)	<input type="text"/>
Year 5 (renewal only)	<input type="text"/>

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 individual must elect to participate in the waiver program, and there must be available resources to assure the health and welfare of the individual within the community.

The applicant is selected for entrance to the waiver based on the date of approval of his/her application. The application includes the Initial Service Plan (ISP), proof of Medicaid eligibility and current Medicaid coverage status.

An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the RRDS pursuant to contracts between the Medicaid agency and the RRDC. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a. **State Classification.** The State is a (*select one*):
- §1634 State
 - SSI Criteria State
 - 209(b) State
- 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

- 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:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:**

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)**
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

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

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- Aged and disabled individuals who have income at:**

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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:

By professionals trained and certified by New York State for completion of Patient Review Instrument (PRI) and SCREEN.

- 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 PRI and SCREEN are the tools used for initial and reevaluation of level of care. The PRI must be completed by a certified NYS Registered Nurse, following completion of an appropriate PRI Training Program. The SCREEN must be completed by a professional who has completed an appropriate SCREEN Training Program. These individuals include certified NYS Registered Nurses, social workers and discharge planning professionals. The qualifications for hospital, nursing home or community professionals completing the PRI and SCREEN instruments are the same.

- 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.

To participate in this waiver program, a nursing facility level of care is necessary. Level of care is determined through completion of the PRI and SCREEN.

The purpose of the PRI instrument is to identify medical events including medical conditions and treatments; capabilities of the individual to perform Activities of Daily Living (ADLs); behavioral difficulties; and specialized services which will result in the potential waiver participant's level of care.

The SCREEN serves two purposes. The first purpose is to determine the individual's potential to be cared for in a

non-nursing home setting based on the availability of appropriate community-based living arrangements, informal supports, the need for restorative services, and the ability to reside in the community without undue risk to self or others, and whether there is a need for nursing home level of care.

The second purpose is to assess an individual for potential mental illness, mental retardation or developmental disabilities and the need for specialized services.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
 - A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

- 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 TBI waiver will employ the use of a PRI and SCREEN to determine a potential waiver participant's initial level of care. The documents will be completed only by individuals trained and certified in the use of the PRI and SCREEN.

Reevaluation of a waiver participant's level of care will occur on an annual basis or when a waiver participant has experienced significant changes in physical, cognitive or behavioral status. The PRI and SCREEN will be used in the reevaluation process, completed by NYS certified assessors. The PRI is completed by a certified NYS Registered Nurse who has successfully completed a PRI training program approved by the NYS DOH. The SCREEN is completed by a certified NYS Registered Nurse, social worker or discharge planning professional who has successfully completed a SCREEN training program approved by the NYS DOH. The qualifications for hospital, nursing home or community professionals completing the PRI and SCREEN instruments are the same. These are the same qualifications for individuals performing the Initial evaluation for LOC.

- 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*):

The Service Coordinator is responsible for tracking dates when reevaluation of level of care is due. This is needed to ensure the waiver participant's eligibility to continue on the waiver program. A component of Service Coordination is to have the reevaluations submitted to the Regional Resource Development Specialist (RRDS) 4-6 weeks prior to the due date to ensure no interruption of service. The RRDS will manage this process. If the RRDS does not receive the PRI and SCREEN in a timely manner, s/he will notify the Service 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 §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The Service Coordinator and the RRDS are both responsible for the safe retention of all records for at least six (6) years. The records will be maintained in their agency ensuring that they will be readily retrievable if requested by CMS or the DOH Waiver Management Staff.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

- i. informed of any feasible alternatives under the waiver; and
 - ii. given the choice of either institutional or home and community-based services.
- a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

- b. Maintenance of Forms.** Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

For all waiver participants who have chosen waiver services and have been approved to participate in the waiver program, copies of the completed Freedom of Choice forms will be maintained for at least three (3) years in the RRDC and in the Service Coordinator's office.

Appendix B: Participant Access and Eligibility

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

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

Potential and active waiver participants with limited fluency in English must have access to services without undue hardship. RRDCs must have arrangements to provide interpretation or translation services for potential and active waiver participants who need them. This is accomplished through a variety of means including; employing bi-lingual staff, resources from the community (e.g. local colleges) and if necessary contracting with interpreters. Those who are non-English speaking may bring a translator of their choice with them to meetings with waiver providers and/or the RRDC. However, they may not be required to bring their own translator, and no person can be denied access on the basis of a RRDC's inability to provide adequate translations.

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:

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Service Type	Service
Statutory Service	Service Coordination
Other Service	Assistive Technology Services
Other Service	Community Integration Counseling
Other Service	Community Transitional Services
Other Service	Environmental Modifications Services
Other Service	Home and Community Support Services
Other Service	Independent Living Skills and Training Services
Other Service	Positive Behavioral Interventions and Support Services
Other Service	Respite Services
Other Service	Structured Day Program Services
Other Service	Substance Abuse Program Services
Other Service	Transportation Services

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):

Service Coordination

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):

Service Coordination is an individually designed intervention which provides primary assistance to the waiver participant in gaining access to needed waiver and Medicaid State Plan services, as well as other local, state and federally funded educational, vocational, social, medical and any other services. These interventions are expected to result in assuring the waiver participant's health and welfare and increasing independence, integration and productivity. In addition, for potential waiver participants desiring to transition from unwanted nursing home placement, the Service Coordinator will assist them in obtaining and coordinating the services that are necessary to return to the community.

The Service Coordinator will assist the waiver participant in the development of the individualized service plan, and will include those individuals chosen by the waiver participant to also participate in the process. Following the approval of the service plan, the Service Coordinator will assist the waiver participant in implementing the plan, as well as reviewing its effectiveness. Throughout his/her involvement with the waiver participant, the Service Coordinator will support and encourage the waiver participant to increase his/her ability to problem-solve, be in control of life situations, and be independent. The Service Coordinator will also assist the waiver participant to complete the Plan of Protective Oversight, see Appendix D.

The Service Coordinator is responsible for the timely submission of subsequent Service Plans and for ongoing monitoring of the provision of all services included in the waiver participant's service plans.

The Service Coordinator is responsible for assuring that all waiver providers and others, as appropriate, have a copy of the Initial Service Plan and are provided with the most recently approved Service Plan.

The Service Coordinator will initiate and oversee the process of assessment and reassessment of the waiver participant's level of care (i.e. need for nursing home level of care) and the review of service plans at such intervals as specified in Appendix D of this request. The provision of Service Coordination under this waiver is cost effective and necessary to avoid institutionalization.

The Service Coordinator is also responsible for assuring that Team Meetings are scheduled and held as designated in the Service Plan, as well as for providing all waiver providers and other waiver participants in the Team Meetings with written summaries of the meetings.

All Service Coordination must be documented in the Service Plan and provided by individuals or agencies approved as a provider of wavier services by the State Department of Health. The provision of Service Coordination under this waiver is cost effective and necessary to avoid institutionalization. The cost effectiveness of this service is demonstrated in Appendix J.

RAI: DOH assures that this waiver will be compliant with all applicable case management regulations no later than 3/3/2010. Any amendments required to achieve such compliance will be submitted to CMS at least 90 days in advance of that date.

Specify applicable (if any) limits on the amount, frequency, or duration of this 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	For Profit Health and Human Service Agency
Agency	Not-For-Profit Health and Human Service Agency
Individual	Independent Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Service Coordination

Provider Category:

Agency

Provider Type:

For Profit Health and Human Service Agency

Provider Qualifications

License (specify):

Certificate (specify):

Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law;
 Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law;
 Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law;
 Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of
 Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or
 Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the
 purpose of providing health and/or human services related activities.

Other Standard (*specify*):

Persons employed as Service Coordinators must be a:

(A) Master of Social Work, Doctorate or Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Providers in Group (A) shall have, at a minimum, one (1) year of experience providing Service Coordination and information, linkages and referral regarding community based services for individuals with disabilities; OR

(B) An individual with a Bachelor's degree and two (2) years experience providing service coordination and information, linkages and referral regarding community based services for individuals with disabilities; OR

(C) An individual with an Associates degree and three (3) years experience providing service coordination to individuals with disabilities and information, linkages and referral regarding community based services for individuals with disabilities; OR

(D) An individual with a high school diploma or equivalent (i.e. GED) with four (4) years experience providing service coordination to individuals with disabilities and information, linkages and referral regarding community based services for individuals with disabilities; OR

(E) An individual who has successfully served as a Regional Resource Development Specialist for a minimum of one (1) year in the TBI Waiver Program.

Individuals with the educational experience listed in Group (A) but who do not meet the experience qualification; individuals with a Bachelor's degree with one (1) year experience providing Service Coordination for individuals with disabilities and knowledge about community resources, individuals with an Associates degree and two (2) years experience providing service coordination to individuals with disabilities and knowledge about community resources and individuals with a High School Diploma and two (2) years of experience providing Service Coordination to individuals with disabilities with knowledge about community resources must be supervised by individuals identified in Group (A), until such time as the experience qualifications identified in A, B, C or D have been met.

For purposes of supervision, the supervisor is expected to meet any potential waiver participants prior to the completion of the Initial Service Plan developed by a Service Coordinator under their supervision; have supervisory meetings with staff on at least a bi-weekly basis; and review and sign-off on all Service Plans.

A supervisor may maintain an active caseload of waiver participants. However, this caseload must be reduced from the maximum limit allowed in relation to his/her supervisory responsibilities.

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

DOH Waiver Management Staff and/or its contractors (RRDC) for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Service Coordination

Provider Category:

Agency

Provider Type:

Not-For-Profit Health and Human Service Agency

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

--

Certificate (*specify*):

Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities

Other Standard (*specify*):

Persons employed as Service Coordinators must be a:

(A) Master of Social Work, Doctorate or Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Providers in Group (A) shall have, at a minimum, one (1) year of experience providing Service Coordination and information, linkages and referral regarding community based services for individuals with disabilities; OR

(B) An individual with a Bachelor's degree and two (2) years experience providing service coordination and information, linkages and referral regarding community based services for individuals with disabilities; OR

(C) An individual with an Associates degree and three (3) years experience providing service coordination to individuals with disabilities and information, linkages and referral regarding community based services for individuals with disabilities; OR

(D) An individual with a high school diploma or equivalent (i.e. GED) with four (4) years experience providing service coordination to individuals with disabilities and information, linkages and referral regarding community based services for individuals with disabilities; OR

(E) An individual who has successfully served as a Regional Resource Development Specialist for a minimum of one (1) year in the TBI Waiver Program.

Individuals with the educational experience listed in Group (A) but who do not meet the experience qualification; individuals with a Bachelor's degree with one (1) year experience providing Service Coordination for individuals with disabilities and knowledge about community resources, individuals with an Associates degree and two (2) years experience providing service coordination to individuals with disabilities and knowledge about community resources and individuals with a High School Diploma and two (2) years of experience providing Service Coordination to individuals with disabilities with knowledge about community resources must be supervised by individuals identified in Group (A), until such time as the experience qualifications identified in A, B, C or D have been met.

For purposes of supervision, the supervisor is expected to meet any potential waiver participants prior to the completion of the Initial Service Plan developed by a Service Coordinator under their supervision; have supervisory meetings with staff on at least a bi-weekly basis; and review and sign-off on all Service Plans.

A supervisor may maintain an active caseload of waiver participants. However, this caseload must be reduced from the maximum limit allowed in relation to his/her supervisory responsibilities.

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

DOH Waiver Management Staff and/or its contractors (RRDC) for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Service Coordination

Provider Category:

Individual

Provider Type:

Independent Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Professionals listed in (A) and (E) of this section, who are self-employed, may also be service coordinators.

(A) Master of Social Work, Doctorate or Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law).

(E) An individual who has successfully served as a Regional Resource Development Specialist for a minimum of one (1) year in the TBI Waiver Program

In addition to the educational requirement, the individuals in (A) must have (3) years experience providing service coordination of multiple community resources to individuals with traumatic brain injury, and have an understanding of the philosophy and content of the Waiver. For individuals in (E) there are no additional requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH Waiver Management Staff and/or its contractors (RRDC) for provider type at the time of provider enrollment. Independent Providers requiring licensure and/or certification are responsible for maintaining the required credentials.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). DOH Survey/Audit Staff will verify the individual's qualifications and certifications through the DOH surveys and/or audits.

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:

Assistive Technology Services

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):

The purpose of this service is to supplement the Medicaid State Plan Service for durable medical equipment and supplies, which provides a broad range of special medical equipment and supplies. The Medicaid State Plan and all other sources must be explored and utilized before considering Assistive Technology.

An Assistive Technological device may include an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or to improve functional capabilities of waiver participants. Assistive Technology service is a service that directly assists a waiver participant in the selection, acquisition, or use of an assistive technology device. This service will only be approved when the requested equipment and supplies improve or maintain the waiver participant's level of independence, ability to access needed supports and services in the community or the waiver participant's safety.

Documentation must describe how the waiver participant's expected use, purpose and intended place of use have been matched to features of the products requested in order to achieve the desired outcome in an efficient and cost effective manner.

The provider of this service is responsible for training the waiver participant, natural supports and paid staff who will be assisting the waiver participant in using the equipment or supplies.

Assistive Technology must be documented in the Service Plan and provided by agencies approved by DOH Waiver Management Staff. The cost effectiveness of this service is demonstrated in Appendix J.

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

Limit of up to \$15,000 per twelve month period unless a contract for Assistive Technology in the amount of \$15,000 or more has been approved by DOH Waiver Management Staff.

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	Providers approved by OMRDD
Agency	Approved providers of PERS
Agency	Licensed Pharmacy
Agency	Providers approved by DOH

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Assistive Technology Services****Provider Category:**

Agency **Provider Type:**

Providers approved by OMRDD

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

Approved to provide Assistive Technology by the NYS Office of Mental Retardation and Developmental Disabilities

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

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment.

Frequency of Verification:

Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). DOH Survey/AuditStaff will verify provider qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Assistive Technology Services****Provider Category:**Agency **Provider Type:**

Approved providers of PERS

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

An approved Provider of PERS contracted with the Local District of Social Services (LDSS)

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

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment.

Frequency of Verification:

Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). DOH Survey/AuditStaff will verify provider qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Assistive Technology Services****Provider Category:**Agency **Provider Type:**

Licensed Pharmacy

Provider Qualifications

License (specify):**Certificate (specify):****Other Standard (specify):**

An establishment registered as a pharmacy by the State Board of Pharmacy pursuant to Article 137 of the NYS Education Law

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

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment.

Frequency of Verification:

Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). DOH Survey/Audit Staff will verify provider qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Assistive Technology Services****Provider Category:**Agency **Provider Type:**

Providers approved by DOH

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

Approved under Section 504 of Title 18 NYCRR (Medical enrollment for providers)

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

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment.

Frequency of Verification:

Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). DOH Survey/Audit Staff will verify provider qualifications and certifications through the DOH surveys and/or audits.

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:

Community Integration Counseling

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):

Community Integration Counseling is an individually designed service intended to assist waiver participants who are experiencing significant problems in managing the emotional difficulties inherent in adjusting to a significant disability and living in the community. It is a counseling service provided to the waiver participant who is coping with altered abilities and skills, a revision of long term expectations or changes in roles in relation to significant others. This service is primarily provided in the provider's office or the waiver participant's home. It is available to waiver participants and/or anyone involved in an ongoing significant relationship with the waiver participant when the issue to be discussed relates directly to the waiver participant.

This service differs from Medicaid State Plan services in that only those professionals listed who have two years of experience providing adjusted related counseling to individuals with traumatic brain injury and their families will be eligible for reimbursement for this service.

While Community Integration Counseling Services are primarily provided in a one-to-one counseling sessions, there are times when it is appropriate to provide this service to the waiver participant in a family counseling or group counseling setting.

The provision of Community Integration Counseling under this waiver is cost-effective and necessary to avoid institutionalization. All Community Integration Counseling must be documented in the Service Plan and provided by agencies approved as a provider of waiver services by the State Department of Health. The cost effectiveness of this service is demonstrated in Appendix J.

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

--

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	For Profit Health and Human Service Agency
Individual	Independent Providers
Agency	Not-For-Profit Health and Human Service Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Community Integration Counseling****Provider Category:**

Agency

Provider Type:

For Profit Health and Human Service Agency

Provider Qualifications**License (specify):**

Certificate (*specify*):

Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law;
 Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law;
 Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law;
 Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of
 Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or
 Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the
 purpose of providing health and/or human services related activities.

Other Standard (*specify*):

Staff of this provider type must be a:

(A) Licensed Psychiatrist (licensed by the NYS Education Department pursuant to Article 131 of the NYS Education Law); Licensed Psychologist (licensed by the NYS Education Department pursuant to Article 153 of the NYS Education Law); Master of Social Work; Doctorate or Master of Psychology; Mental Health Practitioner (licensed by NYS Education Department pursuant to Article 163 of the NYS Education Law), Certified Rehabilitation Counselor (Certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification); or Certified Special Education Teacher (Certified by the NYS Education Department).

Each of these individuals must have, at a minimum, two (2) years of experience providing adjustment related counseling to individuals with traumatic brain injuries and their families. A significant portion of the provider's time which represents this experience must have been spent providing counseling to individuals with traumatic brain injury and their families in order to be considered qualifying experience.

With the prior legal approval of the waiver participant or legal representative, the confidentiality of the waiver participant will be balanced with the need to communicate with other providers of supports and services, and this will be consistent with accepted professional standards.

Individuals listed in Group (A) may supervise the following individuals to perform Community Integration Counseling services:

(B) Licensed Psychiatrist (licensed by the NYS Education Department pursuant to Article 131 of the NYS Education Law); Licensed Psychologist (licensed by the NYS Education Department pursuant to Article 153 of the NYS Education Law); Master of Social Work; Doctorate or Master of Psychology; Mental Health Practitioner (licensed by NYS Education Department pursuant to Article 163 of the NYS Education Law), Certified Rehabilitation Counselor (Certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), or Certified Special Education Teacher (Certified by the NYS Education Department). Individuals in Section (B) must have, at a minimum, one (1) year of experience providing adjustment related counseling to individuals with physical, cognitive, developmental or psychiatric disabilities.

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

DOH and/or its contractors (RRDC) for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Survey/Audit Staff will verify employee qualifications and certifications of provider through the DOH surveys and/or audits.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Community Integration Counseling

Provider Category:

Individual

Provider Type:

Independent Providers

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

Individuals meeting the requirements described in (A) may be Independent Providers and provide this service.

(A) Licensed Psychiatrist (licensed by the NYS Education Department pursuant to Article 131 of the NYS Education Law); Licensed Psychologist (licensed by the NYS Education Department pursuant to Article 153 of the NYS Education Law); Master of Social Work; Doctorate or Master of Psychology; Mental Health Practitioner (licensed by NYS Education Department pursuant to Article 163 of the NYS Education Law), Certified Rehabilitation Counselor (Certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification); or Certified Special Education Teacher (Certified by the NYS Education Department).

Each of these individuals must have, at a minimum, two (2) years of experience providing adjustment related counseling to individuals with traumatic brain injuries and their families. A significant portion of the provider's time which represents this experience must have been spent providing counseling to individuals with traumatic brain injury and their families in order to be considered qualifying experience.

With the prior legal approval of the waiver participant or legal representative, the confidentiality of the waiver participant will be balanced with the need to communicate with other providers of supports and services, and this will be consistent with accepted professional standards.

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

DOH Waiver Management Staff and/or its contractors (RRDC) for provider type at the time of provider enrollment. Independent Providers requiring licensure and/or certification are responsible for maintaining the required credentials.

Frequency of Verification:

Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). DOH Survey/Audit Staff will verify the individuals qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Community Integration Counseling

Provider Category:

Agency

Provider Type:

Not-For-Profit Health and Human Service Agency

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

Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities

Other Standard (*specify*):

Staff of this provider type must be a:

(A) Licensed Psychiatrist (licensed by the NYS Education Department pursuant to Article 131 of the NYS Education Law); Licensed Psychologist (licensed by the NYS Education Department pursuant to Article 153 of the NYS Education Law); Master of Social Work; Doctorate or Master of Psychology; Mental Health Practitioner (licensed by NYS Education Department pursuant to Article

163 of the NYS Education Law), Certified Rehabilitation Counselor (Certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification); or Certified Special Education Teacher (Certified by the NYS Education Department).

Each of these individuals must have, at a minimum, two (2) years of experience providing adjustment related counseling to individuals with traumatic brain injuries and their families. A significant portion of the provider's time which represents this experience must have been spent providing counseling to individuals with traumatic brain injury and their families in order to be considered qualifying experience.

With the prior legal approval of the waiver participant or legal representative, the confidentiality of the waiver participant will be balanced with the need to communicate with other providers of supports and services, and this will be consistent with accepted professional standards.

Individuals listed in Group (A) may supervise the following individuals to perform Community Integration Counseling services:

(B) Licensed Psychiatrist (licensed by the NYS Education Department pursuant to Article 131 of the NYS Education Law); Licensed Psychologist (licensed by the NYS Education Department pursuant to Article 153 of the NYS Education Law); Master of Social Work; Doctorate or Master of Psychology; Mental Health Practitioner (licensed by NYS Education Department pursuant to Article 163 of the NYS Education Law), Certified Rehabilitation Counselor (Certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), or Certified Special Education Teacher (Certified by the NYS Education Department). Individuals in Section (B) must have, at a minimum, one (1) year of experience providing adjustment related counseling to individuals with physical, cognitive, developmental or psychiatric disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH and/or its contractors (RRDC) for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Survey/Audit Staff will verify employee qualifications and certifications provider through the DOH surveys and/or audits.

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:

Community Transitional Services

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):

Community Transitional Services (CTS) are defined as individually designed services intended to assist a waiver participant to transition from a nursing home to living in the community. CTS is a one time service per

waiver enrollment. If the waiver participant has been discontinued from the program and again is a resident of a nursing home, they can access this service again, if needed. This service is only provided when transitioning from a nursing home. These funds are not available to move from the participant's home in the community to another location in the community.

This service includes: the cost of moving furniture and other belongings, security deposits, including broker's fees required to obtain a lease on an apartment or home; purchasing essential furnishings; set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); and health and safety assurances such as pest removal, allergen control or one time cleaning prior to occupancy.

The service will not be used to purchase diversional or recreational items, such as televisions, VCRs/DVDs, or music systems.

The provision of CTS under this waiver is cost-effective and necessary to avoid institutionalization.

All CTS must be documented in the Service Plan. The cost effectiveness of this service is demonstrated in Appendix J.

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

Maximum up to \$3000 per waiver enrollment.

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	For Profit Health and Human Service Agency
Agency	Not-For-Profit Health and Human Service Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transitional Services

Provider Category:

Agency

Provider Type:

For Profit Health and Human Service Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law; Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the purpose of providing health and/or human services related activities.

Other Standard (*specify*):

A for profit health and human service agency that provides Service Coordination. This does not have to be the same agency as the agency providing Service Coordination to the waiver participant .

For the provider type listed, persons employed as Service Coordinators and provide CTS must be a:

(A) Master of Social Work, Doctorate or Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Providers in Group (A) shall have, at a minimum, one (1) year of experience providing Service Coordination and information, linkages and referrals regarding community based services for individuals with disabilities; OR

(B) An individual with a Bachelor's degree and two (2) years experience providing service coordination and information, linkages and referrals regarding community based services for individuals with disabilities; OR

(C) An individual with an Associates degree and three (3) years experience providing Service Coordination and information, linkages and referrals regarding community based services for individuals with disabilities; OR

(D) An individual with a high school diploma or equivalent (i.e. GED) with four (4) years experience providing service coordination and information, linkages and referrals regarding community based services for individuals with disabilities; OR

(E) An individual who has successfully served as a Regional Resource Development Specialist for a minimum of one (1) year in the TBI Waiver Program.

Individuals with the educational experience listed in Group (A) but who do not meet the experience qualification; individuals with a Bachelor's degree in health or human services with one (1) year of experience providing Service Coordination for individuals with disabilities and knowledge about community resources, individuals with an Associates degree and two (2) years experience providing service coordination to individuals with disabilities and knowledge about community resources and individuals with a High School Diploma and two (2) years of experience providing Service Coordination to individuals with disabilities with knowledge about community resources must be supervised by individuals identified in Group (A), until such time as the experience qualifications identified in A, B, C or D have been met.

For purposes of supervision, the supervisor is expected to meet any potential waiver participants prior to the completion of the Initial Service Plan developed by a Service Coordinator under their supervision; have supervisory meetings with staff on at least a bi-weekly basis; and review and sign-off on all Service Plans.

A supervisor may maintain an active caseload of waiver participants. However, this caseload must be reduced from the maximum limit allowed in relation to his/her supervisory responsibilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual (s) maintain the needed license or certification.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transitional Services

Provider Category:

Agency

Provider Type:

Not-For-Profit Health and Human Service Agency

Provider Qualifications**License (specify):**

--

Certificate (specify):

Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities

Other Standard (specify):

A not-for profit health and human service agency that provides Service Coordination. This does not have to be the same agency as the agency providing Service Coordination to the waiver participant . For the provider type listed at the left, persons employed as Service Coordinators and provide CTS must be a:

(A) Master of Social Work, Doctorate or Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Language Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Providers in Group (A) shall have, at a minimum, one (1) year of experience providing Service Coordination and information, linkages and referrals regarding community based services for individuals with disabilities; OR

(B) An individual with a Bachelor's degree and two (2) years experience providing service coordination and information, linkages and referrals regarding community based services for individuals with disabilities; OR

(C) An individual with an Associates degree and three (3) years experience providing Service Coordination and information, linkages and referrals regarding community based services for individuals with disabilities; OR

(D) An individual with a high school diploma or equivalent (i.e. GED) with four (4) years experience providing service coordination and information, linkages and referrals regarding community based services for individuals with disabilities; OR

(E) An individual who has successfully served as a Regional Resource Development Specialist for a minimum of one (1) year in the TBI Waiver Program.

Individuals with the educational experience listed in Group (A) but who do not meet the experience qualification; individuals with a Bachelor's degree in health or human services with one (1) year of experience providing Service Coordination for individuals with disabilities and knowledge about community resources, individuals with an Associates degree and two (2) years experience providing service coordination to individuals with disabilities and knowledge about community resources and individuals with a High School Diploma and two (2) years of experience providing Service Coordination to individuals with disabilities with knowledge about community resources must be supervised by individuals identified in Group (A), until such time as the experience qualifications identified in A, B, C or D have been met.

For purposes of supervision, the supervisor is expected to meet any potential waiver participants prior to the completion of the Initial Service Plan developed by a Service Coordinator under their supervision; have supervisory meetings with staff on at least a bi-weekly basis; and review and sign-off on all Service Plans.

A supervisor may maintain an active caseload of waiver participants. However, this caseload must be reduced from the maximum limit allowed in relation to his/her supervisory responsibilities.

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

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual (s) maintain the needed license or certification.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Modifications Services

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):

Environmental Modifications (E-mods) are internal and external physical adaptations to the home, which are necessary to assure the health, welfare and safety of the waiver participant. These modifications enable the waiver participant to function with greater independence and prevent institutionalization. E-mods may include: the installation of ramps and grab bars; widening of doorways; modifications of bathroom facilities; installation of specialized electrical or plumbing systems to accommodate necessary medical equipment; or any other modification necessary to assure the waiver participant's health, welfare or safety.

E-mods do not include improvements to the home (e.g. carpeting, roof repair, central air conditioning) which are not medically needed or do not support the waiver participant's independence in the home or community.

An E-mod may alter the basic configuration of the waiver participant's home if this alternation is necessary to successfully complete the modification.

Modifications must be provided where the waiver participant lives. If a waiver participant is moving to a new location which requires modifications, the modifications may be completed prior to the waiver participant's move. Also, if an eligible individual is residing in an institution at the time of application, the modifications may be completed no more than 30 days prior to the waiver participant moving into the modified residence. All modifications must meet State and local building codes.

Modifications may also be made to a vehicle if it is the primary means of transportation for the waiver participant. This vehicle may be owned by the waiver participant; a family member who has consistent and on-going contact with the waiver participant; or a non-relative who provides primary, long term support to the waiver participant. These modifications will be approved when the vehicle is used to improve the waiver participant's independence and inclusion in the community.

All E-mods must be documented in the Service Plan and provided by agencies approved by DOH Waiver Management Staff. The cost-effectiveness of this service is demonstrated in Appendix J.

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

Limit of up to \$15,000 per twelve month period unless a contract for Environmental Modifications in the amount of \$15,000 or more has been approved by DOH Waiver Management Staff.

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	Not-For-Profit Health and Human Service Agency
Agency	For Profit Health and Human Service Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Environmental Modifications Services

Provider Category:

Agency

Provider Type:

Not-For-Profit Health and Human Service Agency

Provider Qualifications**License (specify):**

Certificate (specify):

Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities

Other Standard (specify):

Any not-for-profit health and human service agency may provide Environmental Modifications or may subcontract with a qualified person or entity to provide Environmental Modifications. Agencies approved to provide E-mods by the Office of Mental Retardation and Developmental Disabilities (OMRDD) may be approved by DOH Waiver Management Staff to provide this service for the TBI waiver.

The E-mod provider must ensure that individuals working on the E-mods are appropriately qualified and/or licensed to comply with any State and local rules. All materials and products used must also meet any State or local construction requirements. Providers must adhere to safety issues addressed in Article 18 of the New York State Uniform Fire Prevention and Building Code Act as well as all local building codes.

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

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment. For Employer-Employee or subcontractors, the employer/contractor is responsible for verifying that the individual(s) have the needed license or certification.

Frequency of Verification:

Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Environmental Modifications Services

Provider Category:

Agency

Provider Type:

For Profit Health and Human Service Agency

Provider Qualifications**License (specify):**

Certificate (specify):

Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law; Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the purpose of providing health and/or human services related activities.

Other Standard (specify):

Any for profit health and human service agency may provide Environmental Modifications or may subcontract with a qualified person or entity to provide Environmental Modifications. Agencies approved to provide E-mods by the Office of Mental Retardation and Developmental Disabilities (OMRDD) may be approved by DOH Waiver Management Staff to provide this service for the TBI waiver.

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

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment. For Employer-Employee or subcontractors, the employer/contractor is responsible for verifying that the individual(s) have the needed license or certification.

Frequency of Verification:

Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

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 Community Support Services

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):

Home and Community Support Services (HCSS) are the combination of personal care services (ADLs and IADLs) with oversight/supervision services or oversight/supervision as a discrete service primarily at a participant's home. HCSS is provided to a waiver participant who requires assistance with personal care services tasks and whose health and welfare in the community is at risk because oversight/supervision of the participant is required when no personal care task is being performed. HCSS may be provided in Residential Programs for Adults, Enriched Housing or Adult Care Facilities. Services will be complimentary but not duplicative of other services.

HCSS services are provided under the direction and supervision of a Registered Professional Nurse. The Registered Professional Nurse supervising the HCSS staff is responsible for developing a plan and for orienting the HCSS staff.

HCSS differs from Personal Care Services provided under the Medicaid State Plan in that oversight/supervision is not a discrete task for which personal care services are authorized.

The provision of HCSS under this waiver is cost-effective and necessary to avoid institutionalization.

All Home and Community Support Services must be documented in the Service Plan and provided by agencies approved as a provider of wavier services by the DOH. The cost effectiveness of this service is demonstrated in Appendix J.

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

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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	Licensed Home Care Services Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home and Community Support Services

Provider Category:

Agency

Provider Type:

Licensed Home Care Services Agency

Provider Qualifications

License (*specify*):

Licensed under Article 36 of the NYS Public Health Law or exempt from licensure pursuant to 10 NYCRR 765-2.1c

Certificate (*specify*):

--

Other Standard (*specify*):

Staff must be at least 18 years old; be able to follow written and verbal instructions; and have the ability and skills necessary to meet the waiver participant's needs that will be addressed through this service. In addition, staff providing HCSS must have a certificate to indicate that they have successfully completed a training program for Personal Care Aides that is approved by DOH, as well as any additional training as determined by DOH Waiver Management Staff. The HCSS aides must also be in good physical health; that includes documentation of a yearly physical exam, immunizations, a yearly Mantoux skin test and a declaration that one is free from health impairments which pose potential risks to waiver participants or personnel; HCSS aides must be supervised by a Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of NYS Education Law).

RAI: HCSS must be supervised by a registered professional nurse at least every 90 days to comply with Licensed Home Care Service Agency (LHCSA) regulations as providers of HCSS are now required to be a LHCSA.

Nursing supervision must be provided by a registered professional nurse who:

(a) is licensed and currently certified to practice as a registered professional nurse in New York State;

- (b) be in good physical health that the Department of Health requires for employees of certified home health agencies that includes documentation of a yearly physical exam, immunizations, a yearly Mantoux skin test and a declaration that one is free from health impairments which pose potential risks to patients or personnel; and
- (c) meets either of the following qualifications:
- (1) has at least two years satisfactory recent home health care experience; or
 - (2) has a combination of education and experience equivalent to the requirement described in (1) of this section, with at least one year of home health care experience; or
- acts under the direction of a registered professional nurse who meets the qualifications listed in (a) and (b) of this section and either of the qualifications listed in (1) or (2) of this section.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual (s) maintain the needed license or certification.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

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:

Independent Living Skills and Training Services

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):

Independent Living Skills Training and Development (ILST) Services are individually designed to improve or maintain the ability of the waiver participant to live as independently as possible in the community. ILST may be provided in the waiver participant's residence and in the community. This service will be primarily provided on an individual basis; only in the unique situation, where the waiver participants will receive greater benefit from other than a 1:1 situation, will this method of providing service be approved.

ILST must be provided in the environment and situation which will result in the greatest positive outcome for the waiver participant. It is expected that this service will be provided in the waiver participant's environment; for example, in the waiver participant's kitchen as opposed to the provider's kitchen. This expectation is based on the difficulty that many waiver participants experience with transferring or generalizing knowledge and skills from one situation to another. It is recognized that there is a need for some practice of skills before using them in the environment.

Services may include assessment, training, and supervision of or assistance to, an individual with self-care, medication management, task completion, communication skills, interpersonal skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, problem solving skills, money management, pre-vocational skills and ability to maintain a household.

This service may also be used to assist a waiver participant in returning to, or expanding the waiver participant's involvement in meaningful activities, such as volunteering or paid employment. This use of this service for these purposes must occur only after it is clear that the waiver participant is not eligible for services provided through the Vocational and Educational Services for Individuals in Disabilities (VESID) or the Commission for the Blind and Visually Handicapped (CBVH); that VESID and CBVH services have been exhausted; or the activity is not covered by VESID or CBVH services.

It is expected that ILST providers will train natural supports, paid staff and waiver providers to provide the type and level of supports that allows the waiver participant to act and become as independent as possible in Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). This service may continue only when the waiver participant has reasonable goals. It is used for training purposes and not ongoing long term supports and reasons to provide or continue this service must be clearly stated in a service plan.

Independent Living Skills Training and Development under this waiver is cost-effective and necessary to avoid institutionalization.

All ILST must be documented in the Service Plan and provided by individuals or agencies approved as a provider of waiver services by the DOH. The cost effectiveness of this service is demonstrated in Appendix J.

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

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	Not-For-Profit Health and Human Service Agency
Individual	Independent Provider
Agency	For Profit Health and Human Service Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Independent Living Skills and Training Services

Provider Category:

Agency

Provider Type:

Not-For-Profit Health and Human Service Agency

Provider Qualifications

License (specify):

Certificate (specify):

Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities

Other Standard (specify):

Persons employed as an Independent Living Skills and Training provider must be a:

(A) Master of Social Work, Doctorate or Master of Psychology, Registered Physical Therapist

(licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Providers in Group A must have, at a minimum one (1) year of experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent; OR

(B) An individual with a Bachelor's Degree and two (2) years experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent; OR

(C) An individual with an Associates Degree and three (3) years experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent; OR

(D) An individual with a High School Diploma or equivalent (i.e. GED) with four (4) years experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent.

Individuals with the educational experience listed in Group (A), but who do not meet the experience qualifications; individuals with a Bachelor's Degree and one (1) year experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent; individuals with an Associates Degree and two (2) years experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent and individuals with a High School Diploma or equivalent (i.e. GED) and two (2) years experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent; and individuals who have successfully completed two (2) years of providing Home and Community Support Services or Residential Habilitation under the New York State Office of Mental Retardation and Developmental Disabilities HCBS Waiver must be supervised by an individual identified in Group (A), until such time as the experience qualifications identified in A,B,C or D have been met.

For purposes of supervision, the supervisor is expected to meet any potential waiver participants prior to the completion of the Detailed Plan developed by the ILST under their supervision; work with the ILST on completing the functional assessment of the participant; work with the ILST to re-evaluate the participant as needed, but not less than at the completion of the Revised Service Plans and whenever Addenda to the Service Plan are written; have supervisory meetings with staff on at least a bi-weekly basis; provide ongoing supervision and training to staff; and review and sign-off on all Detailed Plans.

The ILST provider agency must make every possible effort to match the skills and experience of the individual provider to the specific goals of the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual (s) maintain the needed license or certification

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Independent Living Skills and Training Services**

Provider Category:Individual **Provider Type:**

Independent Provider

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

Individuals who are Independent Providers may provide ILST services if they meet on of the following: (A) Master of Social Work, Doctorate or Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Language Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). In addition to the educational requirement, such individuals must have three (3) years experience providing functionally based assessments and independent living skills training to individuals with traumatic brain injury, and demonstrate an understanding of the philosophy and content of the HCBS/TBI waiver.

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

DOH Waiver Management Staff and/or its contractors (RRDC) for provider type the time of provider enrollment. Independent Providers requiring licensure and/or certification are responsible for maintaining the required credentials.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). DOH Survey/Audit Staff will verify the individual's qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Independent Living Skills and Training Services**

Provider Category:Agency **Provider Type:**

For Profit Health and Human Service Agency

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

Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law; Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the purpose of providing health and/or human services related activities.

Other Standard (*specify*):

Persons employed as an Independent Living Skills and Training provider must be a:

(A) Master of Social Work, Doctorate or Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Language Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Providers in Group A must have, at a minimum one (1) year of experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent; OR

(B) An individual with a Bachelor's Degree and two (2) years experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent; OR

(C) An individual with an Associates Degree and three (3) years experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent; OR

(D) An individual with a High School Diploma or equivalent (i.e. GED) with four (4) years experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent.

Individuals with the educational experience listed in Group (A), but who do not meet the experience qualifications; individuals with a Bachelor's Degree and one (1) year experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent; individuals with an Associates Degree and two (2) years experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent and individuals with a High School Diploma or equivalent (i.e. GED) and two (2) years experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent; and individuals who have successfully completed two (2) years of providing Home and Community Support Services or Residential Habilitation under the New York State Office of Mental Retardation and Developmental Disabilities HCBS Waiver must be supervised by an individual identified in Group (A), until such time as the experience qualifications identified in A,B,C or D have been met.

For purposes of supervision, the supervisor is expected to meet any potential waiver participants prior to the completion of the Detailed Plan developed by the ILST under their supervision; work with the ILST on completing the functional assessment of the participant; work with the ILST to re-evaluate the participant as needed, but not less than at the completion of the Revised Service Plans and whenever Addenda to the Service Plan are written; have supervisory meetings with staff on at least a bi-weekly basis; provide ongoing supervision and training to staff; and review and sign-off on all Detailed Plans.

The ILST provider agency must make every possible effort to match the skills and experience of the individual provider to the specific goals of the participant.

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

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual (s) maintain the needed license or certification

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits

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:

Positive Behavioral Interventions and Support Services

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):

Positive Behavioral Interventions and Support (PBIS) are individually designed and are provided to waiver participants who have significant behavioral difficulties that jeopardize their ability to remain in the community of choice due to inappropriate responses to events in their environment.

These services include but are not limited to: a comprehensive assessment of the individual's behavior (in the context of their medical diagnosis as determined by the appropriate health or mental health professional), skills and abilities, existing and potential natural and paid supports and the environment; the development and implementation of a holistic structured behavioral treatment plan (Detailed Plan) including specific realistic goals which can also be utilized by other providers and natural supports; the training of family, natural supports and other providers so that they can also effectively use the basic principles of the behavioral plan; and regular reassessment of the effectiveness of the behavioral treatment plan, making adjustments to the plan as needed.

The primary focus of the Detailed Plan for this service is to decrease the intensity and/or frequency of the targeted behaviors and to teach safer or more socially appropriate behaviors. None of these activities shall fall within the scope of the practice of mental health counseling set forth in Article 163 of the NYS Education Law.

The Detailed Plan must include a clear description of successive levels of intervention, starting with the simplest and least intrusive level. All plans must be written in a manner so that all natural and paid supports will be able to follow the plan. An emergency intervention plan is warranted when there is the possibility of the waiver participant becoming a threat to him or herself or others.

The two key positions in PBIS are the Program Director and the Behavioral Specialist. The Program Director is responsible for assessing the waiver participant and developing the PBIS plan for each waiver participant. The Director may work as a Behavioral Specialist, or may provide ongoing supervision to a Behavioral Specialist who will implement the plan. If a provider has more than one individual who meets the qualifications for the Program Director, all qualified individuals may develop individual PBIS plans. The Behavioral Specialist is responsible for implementation of the Detailed Plan under the direction of the Program Director.

The PBIS should be provided in the situation where the severe maladaptive behavior occurs. The provision of PBIS must be documented in the Service Plan and be provided by individuals or agencies approved as a provider of this waiver service by the DOH Waiver Management Staff.

The provision of PBIS under this waiver is cost effective and necessary to avoid institutionalization. The cost effectiveness of this service is demonstrated in Appendix J.

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

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	Not-For-Profit Health and Human Service Agency
Agency	For Profit Health and Human Service Agency
Individual	Independent Providers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Positive Behavioral Interventions and Support Services

Provider Category:

Agency

Provider Type:

Not-For-Profit Health and Human Service Agency

Provider Qualifications

License (specify):

Certificate (specify):

Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities

Other Standard (specify):

The providers listed at the left must employ a Program Director who is a:

(A) Licensed psychiatrist (licensed by the NYS Education Department pursuant to Article 131 of the NYS Education Law) with one year experience providing behavioral services;

(B) Licensed psychologist (licensed by the NYS Education Department pursuant to Article 153 of the NYS Education Law) with one year experience in providing behavioral services or traumatic brain injury services;

(C) Master of Social Work, Doctorate or Master degree in Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Mental Health Practitioner (licensed by NYS Education Department pursuant to Article 163 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Language Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Each of the individuals in (C) must have, at a minimum, two years of experience providing neurobehavioral services;

(D) An individual who has been a Behavioral Specialist for two (2) years and has successfully completed an apprenticeship program offered by the Statewide Neurobehavioral Resource Project.

A Behavioral Specialist must be a:

(A) Person with a Bachelor's degree;

(B) Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law);

(C) Certified Occupational Therapy Assistant (certified by the NYS Education Department pursuant to Article 156 of the NYS Education Law); or

(D) Physical Therapy Assistant (certified by the NYS Education Department pursuant to Article 136 of the NYS Education Law).

Behavioral Specialists must have at least one (1) year of experience working with individuals with traumatic brain injury, other disabilities or behavioral difficulties. The Behavioral Specialist must successfully complete training in behavioral analysis and crisis intervention techniques which is provided by the Positive Behavioral Interventions and Supports program. The Behavioral Specialist must be supervised by the Program Director. Supervision must occur no less than biweekly to review the caseload and must be more frequent when there is a new waiver participant, new provider or when significant behavioral issues arise.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual (s) maintain the needed license or certification.

Frequency of Verification:

Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Waiver Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Positive Behavioral Interventions and Support Services

Provider Category:

Agency

Provider Type:

For Profit Health and Human Service Agency

Provider Qualifications

License (specify):

Certificate (specify):

Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law; Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the purpose of providing health and/or human services related activities.

Other Standard (specify):

The providers must employ a Program Director who is a:

(A) Licensed psychiatrist (licensed by the NYS Education Department pursuant to Article 131 of the NYS Education Law) with one year experience providing behavioral services;

(B) Licensed psychologist (licensed by the NYS Education Department pursuant to Article 153 of the NYS Education Law) with one year experience in providing behavioral services or traumatic brain injury services;

(C) Master of Social Work, Doctorate or Master degree in Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Mental Health Practitioner (licensed by NYS Education Department pursuant to Article 163 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Language Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article

156 of the NYS Education Law). Each of the individuals in (C) must have, at a minimum, two years of experience providing neurobehavioral services;

(D) An individual who has been a Behavioral Specialist for two (2) years and has successfully completed an apprenticeship program offered by the Statewide Neurobehavioral Resource Project.

A Behavioral Specialist must be a:

(A) Person with a Bachelor's degree;

(B) Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law);

(C) Certified Occupational Therapy Assistant (certified by the NYS Education Department pursuant to Article 156 of the NYS Education Law); or

(D) Physical Therapy Assistant (certified by the NYS Education Department pursuant to Article 136 of the NYS Education Law).

Behavioral Specialists must have at least one (1) year of experience working with individuals with traumatic brain injury, other disabilities or behavioral difficulties. The Behavioral Specialist must successfully complete training in behavioral analysis and crisis intervention techniques which is provided by the Positive Behavioral Interventions and Supports program. The Behavioral Specialist must be supervised by the Program Director. Supervision must occur no less than biweekly to review the caseload and must be more frequent when there is a new waiver participant, new provider or when significant behavioral issues arise.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual (s) maintain the needed license or certification.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Positive Behavioral Interventions and Support Services

Provider Category:

Individual

Provider Type:

Independent Providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Independent Providers must meet the same standards as the Program Director specified below in order to provide PBIS services.

A Program Director must be a:

(A) Licensed psychiatrist (licensed by the NYS Education Department pursuant to Article 131 of the NYS Education Law) with one year experience providing behavioral services;

(B) Licensed psychologist (licensed by the NYS Education Department pursuant to Article 153 of the NYS Education Law) with one year experience in providing behavioral services or traumatic brain injury services;

(C) Master of Social Work, Doctorate or Master degree in Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Mental Health Practitioner (licensed by NYS Education Department pursuant to Article 163 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special

Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Language Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Each of the individuals in (C) must have, at a minimum, two years of experience providing neurobehavioral services;
 (D) An individual who has been a Behavioral Specialist for two (2) years and has successfully completed an apprenticeship program offered by the Statewide Neurobehavioral Resource Project.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment. Independent Providers requiring licensure and/or certification are responsible for maintaining the required credentials.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

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:

Respite Services

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):

Respite Services is an individually designed service intended to provide relief to natural, non-paid supports who provide primary care and support to a waiver participant. The primary location for the provision of this service is in the waiver participant's home. Respite Services are provided in a 24 hour block of time.

Respite Services may be provided in the waiver participant's home or in another dwelling. Services may be provided in another dwelling in the community if this is acceptable to the waiver participant and the people living in the other dwelling. If a waiver participant is interested in seeking a brief respite in a nursing home, this can be accomplished through a Scheduled Short Term Admission, and is not considered a Waiver Service.

Providers of the Respite Services must meet the same standards and qualifications as the direct care providers of Home and Community Support Services (HCSS). If the services needed by the waiver participant exceed the type of care and support provided by the Home and Community Support Services, then other appropriate providers must be included in the plan for Respite Services and will be reimbursed separately from Respite Services.

Respite Services must be documented in the Service Plan and provided by agencies approved as a provider of waiver services by DOH. The cost effectiveness of this service is demonstrated in Appendix J.

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

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	Agencies approved to provide Home and Community Support Services (HCSS)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Respite Services

Provider Category:

Agency

Provider Type:

Agencies approved to provide Home and Community Support Services (HCSS)

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Staff providing Respite must be at least 18 years old; be able to follow written and verbal instructions; and have the ability and skills necessary to meet the waiver participants' needs that will be addressed through this service. In addition, staff providing Respite must have a certificate to indicate that they have successfully completed a training program for Personal care Aides that is approved by DOH.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual (s) maintain the needed license or certification

Frequency of Verification:

Upon Signed provider agreement. The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

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:

Structured Day Program Services

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):

Structured Day Program Services are individually designed services provided in an outpatient congregate setting or in the community, to improve or maintain the waiver participant's skills and ability to live as independently as possible in the community. Services may include assessment, training and supervision to an individual with self-care, task completion, communication skills, interpersonal skills, problem-solving skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, money management skills and ability to maintain a household.

This service may augment some aspects of this waiver, other services, as well as Medicaid State Plan services when reinforcement of skills is necessary. This is due to the difficulty that many individuals have with transferring or generalizing skills learned in one setting to other settings, and the need for consistent reinforcement of skills. The Service Plan should address how the services are complimentary and not duplicative. This service is intended to provide an opportunity for the waiver participant to continue to strengthen skills that are necessary for greater independence, improved productivity and/or increased community inclusion.

The Structured Day Program may be provided within a variety of settings and with very different goals. Waiver participants may choose to participate in a Structured Day Program that emphasizes basic work skills, such as punctuality, problem solving and effectively communicating with co-workers and supervisors. Other Structured Day Programs may focus on specific job skills, such as computer operation, cooking, etc. Other waiver participants, for whom employment is not an immediate or long-term goal, may focus on socialization skills.

The Structured Day Program is responsible for providing appropriate and adequate space to meet the functional needs of the waiver participants served. The program must provide adequate protection for the program waiver participants' safety and fire safety, including periodic fire drills (minimum of 2 fire drills per year), and must be located in a building that meets all provisions of the NYS Uniform Fire Prevention and Building Codes. In addition, access to the program must meet and adhere to requirements of the Americans with Disabilities Act. The RRDS or DOH Waiver Management Staff may determine the appropriateness of the physical space for the TBI Waiver participants.

The provision of Structured Day Programs under this waiver is cost-effective and necessary to avoid institutionalization. This service differs from adult day health care services available under the Medicaid State Plan in that they are not required to be provided under the direct order of a physician.

The Structured Day Program must be documented in the Service Plan and provided by agencies approved as a provider of waiver services by DOH. The cost effectiveness of this service is demonstrated in Appendix J.

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

--

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	Not-For-Profit Health and Human Service Agency
Agency	For Profit Health and Human Service Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Structured Day Program Services

Provider Category:

Agency

Provider Type:

Not-For-Profit Health and Human Service Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities

Other Standard (*specify*):

The provider types at the left must have a Structured Day Program Director who is a:
 (A) Master of Social Work, Doctorate or Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Language Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Individuals in Group (A) must have, at a minimum, one (1) year of experience providing functional assessments, Positive Behavioral Interventions and Support Services, or Structured Day Program services to individuals with disabilities: OR

(B) be an individual with a Bachelor's degree and two (2) years of experience providing functional assessments, Positive Behavioral Interventions and Support Services or Structured Day Program services to individuals with disabilities.

In addition to a required Program Director, a Structured Day Program may employ program staff. Program staff must be at least 18 years old with a minimum of a High School Diploma or equivalent (i.e. GED); be able to follow written and verbal instructions; and have the ability, skills, training and supervision necessary to meet the waiver participant's needs that will be addressed through this service to assure the health and welfare of the waiver participant.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual (s) maintain the needed license or certification.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Structured Day Program Services

Provider Category:

Agency

Provider Type:

For Profit Health and Human Service Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law; Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the purpose of providing health and/or human services related activities.

Other Standard (*specify*):

The provider types at the left must have a Structured Day Program Director who is a:

(A) Master of Social Work, Doctorate or Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Language Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Individuals in Group (A) must have, at a minimum, one (1) year of experience providing functional assessments, Positive Behavioral Interventions and Support Services, or Structured Day Program services to individuals with disabilities: OR

(B) be an individual with a Bachelor's degree and two (2) years of experience providing functional assessments, Positive Behavioral Interventions and Support Services or Structured Day Program services to individuals with disabilities.

In addition to a required Program Director, a Structured Day Program may employ program staff. Program staff must be at least 18 years old with a minimum of a High School Diploma or equivalent (i.e. GED); be able to follow written and verbal instructions; and have the ability, skills, training and supervision necessary to meet the waiver participant's needs that will be addressed through this service to assure the health and welfare of the waiver participant..

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual (s) maintain the needed license or certification.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

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:

Substance Abuse Program Services

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):

Substance Abuse Program Services provide individually designed interventions to reduce/eliminate the use of alcohol and/or other substances by the waiver participant, which, if not effectively dealt with, will interfere with the individual's ability to remain in the community.

Substance Abuse Programs Services are provided in an outpatient, congregate setting and may include: an assessment of the individual's substance abuse history; learning/behavioral assessment; development of a structured treatment plan which reflects an understanding of the waiver participant's substance abuse history and cognitive abilities; implementation of the plan; on-going education and training of the waiver participant, family members, natural supports and all other service providers; individualized relapse strategies; periodic reassessment of the plan; and ongoing support. The treatment plan may include both group and individual interventions and reflects the use of curriculum and materials adopted from a traditional substance abuse program to meet the needs of individuals with traumatic brain injury.

The program must have a fully developed plan which details how it will work with existing community support programs, such as Alcoholic Anonymous and secular organizations for sobriety that provide ongoing support to individuals with substance abuse problems. Substance Abuse Program Services will also provide technical assistance to community-based self-help/support groups to improve the ability of the community support programs to provide ongoing supports to individuals with traumatic brain injury.

This program differs from State plan service in that these services will integrate non-residential services with participant specific interventions in the community in order to reinforce the training in a real life situation. The provision of Substance Abuse Programs Services under this waiver is cost-effective and necessary to avoid institutionalization.

All Substance Abuse Programs Services must be documented in the service plan and provided by agencies approved as providers of this waiver service by the Department of Health AND certified/licensed by the State Office of Alcoholism and Substance Abuse Services (OASAS).The cost effectiveness of this service in demonstrated in Appendix J.

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

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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	Not-For-Profit Health and Human Service Agency

Agency	For Profit Health and Human Service Agency
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Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Substance Abuse Program Services

Provider Category:

Agency

Provider Type:

Not-For-Profit Health and Human Service Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities

Other Standard (*specify*):

Substance Abuse Program Provider agencies must be certified/licensed by the Office of Alcoholism and Substance Abuse Services (OASAS).

The Program Director must be a health care professional with an advanced human services degree:

(A) Master of Social Work, Doctorate or Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Language Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law).

AND have at least one (1) year experience providing services to individuals with traumatic brain injury or providing services to individuals who abuse substances, (e.g. Credentialed Alcoholism and Substance Abuse Counselor). If the Director has experience in only one of these areas, then there must be staff members in positions of significant policy making, procedure development and/or provision of service who have experience in the other.

At least one of the staff members must be a Credentialed Alcoholism and Substance Abuse Counselor.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider enrollment. For Employer-Employee, the employer is responsible for verifying that the individual (s) maintain the needed license or certification.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys and/or audits.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Substance Abuse Program Services

Provider Category:Agency **Provider Type:**

For Profit Health and Human Service Agency

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

Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law;
 Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law;
 Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law;
 Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Partnership; Certificate of
 Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or
 Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the
 purpose of providing health and/or human services related activities.

Other Standard (specify):

Substance Abuse Program Services Providers must be certified/licensed by the Office of
 Alcoholism and Substance Abuse Services (OASAS).

The Program Director must be a health care professional with an advanced human services
 degree:

(A) Master of Social Work, Doctorate or Master of Psychology, Registered Physical Therapist
 (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law),
 Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139
 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education
 Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a
 Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor
 Certification), Licensed Speech Language Pathologist (licensed by the NYS Education Department
 pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed
 by the NYS Education Department pursuant to Article 156 of the NYS Education Law).
 AND have at least one (1) year experience providing services to individuals with traumatic brain
 injury or providing services to individuals who abuse substances, (e.g. Credentialed Alcoholism and
 Substance Abuse Counselor). If the Director has experience in only one of these areas, then there
 must be staff members in positions of significant policy making, procedure development and/or
 provision of service who have experience in the other.

At least one of the staff members must be a Credentialed Alcoholism and Substance Abuse
 Counselor.

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

DOH Waiver Management Staff and/or its contractors for provider type at the time of provider
 enrollment. For Employer-Employee, the employer is responsible for verifying that the individual
 (s) maintain the needed license or certification

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report any subsequent change in
 status to DOH Waiver Management Staff and/or its contractors (RRDC). For Employer-Employee,
 the employer must verify license or certification upon hire and annually thereafter. DOH
 Survey/Audit Staff will verify employee qualifications and certifications through the DOH surveys
 and/or audits.

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:

Transportation Services

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):

Transportation is offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources as specified in the Service Plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.

Transportation services under the waiver shall be offered in accordance with the individual's Service Plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

The need for transportation must be documented in the Service Plan. The Service Coordinator is responsible for maintaining complete and current records of the waiver transportation provided.

Specify applicable (if any) limits on the amount, frequency, or duration of this 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
Individual	Various Providers approved by the Service Coordinators
Agency	Common Carrier & specialized transportaion

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transportation Services

Provider Category:

Individual

Provider Type:

Various Providers approved by the Service Coordinators

Provider Qualifications

License (specify):

New York State Drivers License

Certificate (specify):

Other Standard (specify):

Individual providers must have a current New York State Drivers License. Must drive a New York State registered, inspected and insured vehicle and must be included in the Service Plan. The

Medicaid Agency will furnish this transportation as an administrative expense.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Medicaid Agency. Individual provider is responsible for maintaining required licensure and vehicle registration, inspection and insurance.

Frequency of Verification:

Upon transportation approval the Local Medicaid Agency insures that the transportation provider meets all provider qualifications. The waiver service provider must report any subsequent change in status to the Local Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transportation Services

Provider Category:

Agency

Provider Type:

Common Carrier & specialized transportaion

Provider Qualifications

License (specify):

New York State Drivers License

Certificate (specify):

Other Standard (specify):

Any currently approved provider of State Plan Medicaid Transportation is eligible to provide HCBS/TBI waiver transportation.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Regulatory Agency. For employer/employee, the employer is responsible for verifying that the individual(s) providing this service maintain the needed licensure.

Frequency of Verification:

The State Regulatory Agency oversees providers and informs the Medicaid Agency when providers are out of compliance through surveys and/or inspections.

Appendix C: Participant Services

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

- b. Alternate Provision of Case Management Services to Waiver Participants.** When case management is not a covered waiver service, 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 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.*

None of the above apply (i.e., case management is furnished as a waiver service)

- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

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 Public Health Law section 2899-a and Executive Law section 845-b, every residential health care facility which is licensed under article 28 of the Public Health Law, and any certified home health agency, licensed home care services agency or long term home health care program certified, licensed or authorized under article 36 of the Public Health Law, to provide services to patients, residents or clients shall request a criminal history record check by the Department of Health for each prospective employee to provide direct 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. 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 the Department of Health. 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 regulations (e.g., appropriate direct observation and evaluation). A provider requesting a criminal history record check obtains the fingerprints accompanied by two forms of identification to be submitted to the Department. Providers must maintain and retain current records including a roster of current employees who were reviewed to which the Department shall have immediate and unrestricted access for the purpose of monitoring compliance. Verification of compliance with the criminal history record check regulations are included in DOH's surveillance process. At the time of surveillance, DOH surveyors utilize a standardized tool to evaluate compliance with the criminal history background checks regulations. If a provider is found to not be in compliance with the regulations, a statement of deficiency(ies) is issued for which the provider has to provide a plan of correction. Licensed Home Care Agencies and Certified Home Health Agencies are surveyed, at a minimum, one time every three (3) years.

RAI: The TBI waiver program does not provide waiver services in any "residential health care facility," i.e., nursing home. The Office of Mental Health (OMH) does have "Residential Programs" in the community which are certified every 3 years with annual surveys of each site. The TBI waiver would like to have the possibility to serve individuals in this setting should the need arise to better serve a waiver participant. Should this situation occur, the Department would communicate with OMH to ensure that the facility was appropriately certified and no deficiencies were noted on annual survey.

- 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):

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).**
 - i. Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type
Residential Programs for Adults
Enriched Housing
Adult Care Facility

- ii. Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The survey component of DOH, through its survey process evaluates the home and community character of Adult Care Facilities, enriched housing programs and residences for adults.

Adult Care Facilities (Adult Homes) are established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care and supervision to five or more adults unrelated to the operator. Adult Care Facilities (Adult Homes) are congregate facilities where residents can choose their room based on availability. Adult Care Facilities (Adult Homes) provide for a minimum of three congregate meals in communal dining areas and an evening snack. Residents are also permitted to keep food in their room if desired. Residents are encouraged to participate in facility and community activities. In addition, each Adult Care Facility (Adult Home) has a diversified program of individual and group activities that provides for activities within the facility and arranges for resident participation in community-based and community-sponsored activities. Each resident has the opportunity to have private communications. Each facility must provide, without charge, space for residents to meet in privacy with service providers. Adult Care Facility (Adult Home) residents are permitted to leave and return to the facility at reasonable hours. Residents may also choose their own community-based health care providers, have their own motor vehicles and furnish/decorate and maintain their rooms.

Enriched Housing Programs are adult-care facilities established and operated for the purpose of providing long-term residential care to five or more adults, primarily persons 65 years of age or older, in community-integrated settings resembling independent housing units. Such programs provide or arrange the provision of room, and provide board, housekeeping, personal care and supervision. Enriched Housing Programs must serve at a minimum, one hot midday or evening meal per day seven days a week in a congregate setting. In addition, residents have free access to kitchen facilities for the purpose of preparing their own noncongregate meals and snacks and may keep food in their housing unit as desired. Enriched Housing staff assists residents, to the extent necessary, with shopping, preparation and clean-up of noncongregate meals. Residents are encouraged to maintain family and community ties and to develop new ones, as well as participate in community activities. Each resident has the opportunity to have private communications. Enriched Housing Programs provide, free of charge, space for residents to meet in privacy with service providers. Residents are able to leave and return to the facility as desired. In addition, residents may choose their own community-based health care providers, have their own motor vehicles and furnish/decorate and maintain their own housing unit.

The purpose of Residential Programs for Adults is to provide residential services which support and assist individuals diagnosed with a severe and persistent mental illness with their goal of integration into the community. Services provided in such programs focus upon intensive, goal-oriented intervention, within a structured program setting, to address issues identified by and specific to resident’s needs regarding community integration or goal oriented interventions which focus on improving or

maintaining resident skills that enable a resident to remain living in community housing. Types of residential programs include apartment and congregate living. No more than two persons can share a bedroom and each resident must have at least 75 square feet of living space if sharing a bedroom. Residents may furnish/decorate and maintain their rooms. The program provides room and board within stable housing with on-site services which is supported by transportation activities and other services within the community.

RAI: Waiver services will not be provided to individuals living in enriched housing and adult care facilities who would not be waiver eligible. Current intake, eligibility and assessment processes for the TBI waiver prevent this from occurring.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Programs for Adults

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Community Integration Counseling	<input checked="" type="checkbox"/>
Assistive Technology Services	<input checked="" type="checkbox"/>
Structured Day Program Services	<input type="checkbox"/>
Home and Community Support Services	<input checked="" type="checkbox"/>
Substance Abuse Program Services	<input type="checkbox"/>
Community Transitional Services	<input type="checkbox"/>
Environmental Modifications Services	<input type="checkbox"/>
Transportation Services	<input type="checkbox"/>
Independent Living Skills and Training Services	<input checked="" type="checkbox"/>
Positive Behavioral Interventions and Support Services	<input checked="" type="checkbox"/>
Service Coordination	<input checked="" type="checkbox"/>
Respite Services	<input type="checkbox"/>

Facility Capacity Limit:

48 beds

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>

Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Enriched Housing

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Community Integration Counseling	<input checked="" type="checkbox"/>
Assistive Technology Services	<input checked="" type="checkbox"/>
Structured Day Program Services	<input type="checkbox"/>
Home and Community Support Services	<input checked="" type="checkbox"/>
Substance Abuse Program Services	<input type="checkbox"/>
Community Transitional Services	<input type="checkbox"/>
Environmental Modifications Services	<input type="checkbox"/>
Transportation Services	<input type="checkbox"/>
Independent Living Skills and Training Services	<input checked="" type="checkbox"/>
Positive Behavioral Interventions and Support Services	<input checked="" type="checkbox"/>
Service Coordination	<input checked="" type="checkbox"/>
Respite Services	<input type="checkbox"/>

Facility Capacity Limit:

N/A

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Care Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Community Integration Counseling	<input checked="" type="checkbox"/>
Assistive Technology Services	<input checked="" type="checkbox"/>
Structured Day Program Services	<input type="checkbox"/>
Home and Community Support Services	<input checked="" type="checkbox"/>
Substance Abuse Program Services	<input type="checkbox"/>
Community Transitional Services	<input type="checkbox"/>
Environmental Modifications Services	<input type="checkbox"/>
Transportation Services	<input type="checkbox"/>
Independent Living Skills and Training Services	<input checked="" type="checkbox"/>
Positive Behavioral Interventions and Support Services	<input checked="" type="checkbox"/>
Service Coordination	<input checked="" type="checkbox"/>
Respite Services	<input type="checkbox"/>

Facility Capacity Limit:

200 beds

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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:

DOH Waiver Management Staff and/or its contractors will conduct statewide regional meetings and open forums along with information sessions in order to continue to educate the community at large about the TBI waiver. The RRDS will be directed by DOH Waiver Management Staff to facilitate meetings with potential providers to inform them of the opportunities to provide waiver services.

The approved TBI waiver application will be posted on the DOH website, as will the program manual, providing ready access, to the necessary information for all potential providers. Providers may seek to enroll at anytime during the course of the waiver.

The process is as follows:

- 1) An entity informs DOH Waiver Management Staff or RRDC of its interest in becoming a provider.
- 2) The potential provider is then directed to the DOH website, which explains the process for becoming a provider and a copy of the Provider Agreement. Medicaid Enrollment forms are obtained from the RRDS.
- 3) The potential provider is then interviewed by the RRDS, using a standard interview form. The RRDS reviews the Policy and Procedures developed by the potential provider.
- 4) The RRDS completes an interview form and then makes a recommendation to DOH Waiver Management Staff. The DOH Waiver Management Staff review the interview form including the comments of the RRDS.
- 5) DOH Waiver Management Staff reviews the recommendations of the RRDS and if it concurs, the provider is approved for participation.
- 6) Information is then sent to eMedNY so the provider can be entered into the claims processing system. The provider receives official notification of approval, and a Billing Manual.

Any willing and qualified provider may, at any time, seek approval for adding services. If a provider seeks to be approved for additional services, the RRDS will once again interview the provider as mentioned above.

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 D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Initial Service Plan (ISP), Revised Service Plan (RSP), Addendum

- 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:*

The entity providing Service Coordination may provide other waiver services, however an individual Service Coordinator (SC) is not permitted to provide other waiver services to a participant they serve. This addresses the need to accommodate the State's diversity in culture/language. For example, some waiver providers actually specialize in providing linguistically competent services to participants whose primary language is not English and these waiver providers may offer both Service Coordination and other waiver services. This decision also contributes to assuring that the participants have maximum choice among providers.

The following safeguards ensure that the Service Plan (SP) development is conducted in the best interests of the participant.

1. The potential participant meets with the RRDS to receive information about the waiver and service providers. The RRDS explains that he/she has a choice of all service providers and encourages the potential participant to interview Service Coordinators to make an informed choice;
2. The participant signs a Service Coordinator Selection Form indicating understanding of the right to choose a SC, and may change the SC at any time and still be eligible for the waiver;
3. The SC is responsible for providing the potential participant with objective information regarding all waiver providers;
4. The participant must sign the list of waiver providers in the region affirming that he/she was given a choice of providers;
5. Annually, the SC is responsible for reviewing the Participant Rights Form with the participant. This form describes the right of the participant to select or change providers, and participate in the development, review and approval of all Service Plans. The participant is given a copy of the signed form.
6. Participant choice is inherent to the SP development process. The SC is responsible for providing unbiased and comprehensive information to the participant about available services and service providers.
7. The participant's signature is required on the Initial Service Plan (ISP), the Revised Service Plan (RSP) and Addendums to the SP. The participant's signature is required in order to indicate that the participant agrees with the information that is included in the Service Plan. The participant must receive a copy of each signed Service Plan.
8. Each SP contains a list of the services requested, the providers of the services; and duration and frequency of each service.
9. If the participant does not want to sign the Service Plan, the participant is given the opportunity for a Conference with the RRDS and/or a Fair Hearing;
10. The participant has the right to change waiver service providers at any time during the period covered by an

approved Service Plan. With the assistance of their Service Coordinator, the participant completes a Change of Provider Form, which is then sent to the RRDS. The form is reviewed and approved by the RRDS and a copy sent to the participant, the SC and the current and new waiver service providers. If the participant wishes to change Service Coordinators, the participant contacts the RRDS directly. The RRDS will provide information to the participant about providers of Service Coordination and assist the participant with completing the SC Selection form.

11. A toll-free Complaint Line has been established for participants to use if they believe their rights are being violated. All calls to the Complaint Line are forwarded to DOH Management Staff and the appropriate RRDS for prompt investigation;

12. The survey component of DOH will survey approximately 30% of all waiver service providers each year and more frequently if DOH Waiver Management Staff identifies concerns about the provider's adherence to waiver requirements. The survey focuses primarily on waiver service provider's compliance with waiver policies, including the right of a participant to freely choose his/her waiver service provider. If the survey identifies trends that indicate that waiver service providers are not giving a choice, the waiver service provider is subject to remedial action which may include termination of the Provider Agreement with DOH.

13 Each waiver service provider as a part of self-monitoring is required to conduct a consumer satisfaction survey of participants annually. The findings of these surveys, including any changes to agency policy based on these findings, are reviewed during a DOH survey. The Clinical Consultant (CC), RRDS and DOH may request to review these findings at any time.

14. The CC functions as a liaison between the DOH Waiver Management Staff, Regional Resource Development Centers (RRDCs) and waiver service providers. The CC is responsible for working with DOH Waiver Management Staff to ensure quality management. DOH Waiver Management Staff, through the RRDS, CC and/or surveyors, will investigate all complaints and implement remedial action as appropriate;

15. The SC is responsible for providing and updating a Contact List of waiver service providers to the participant. The List includes the name and phone numbers of the all waiver service providers and their supervisors, the appropriate RRDS, and the Complaint Line for easy access by the participant.

16. All participants receive a refrigerator magnet with the toll- free phone number for the Complaint Line;

17. The RRDS is a separate entity from any providers of waiver services. The RRDS are employed by the RRDC under contract to DOH;

18. The RRDS reviews and approves each SP to assure that it protects the participant's health and welfare, and reflects participant choice;

19. The CC retrospectively reviews at least five-percent (5%) of all Service Plans annually including all Plans costing over an amount established by DOH for quality assurance, maximum participant choice and independence, and for cost effectiveness.

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 RRDS provides detailed written information to the waiver participant and/or legal guardian regarding the purpose of the TBI waiver, philosophy of the TBI waiver, available services, application and Service Plan development process, role of the Service Coordinator and a list of available Service Coordinators and the /or a Fair Hearing. The waiver participant may include any person of his/her choosing to assist in the development of the Service Plan. The participant signs the Potential Participant Interview Applicant Acknowledgement form (and receives a copy) which identifies they have been informed of the above information.

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):

The Service Coordinator assists the potential waiver participant with the waiver application process and coordinates and monitors the provision of all services in the Service Plan. He/she will assist the waiver participant in the development of the Initial Service Plan (ISP), and will include those individuals chosen by the waiver participant to also participate in that process. The goal of the Service Plan is to increase the waiver participant's independence, productivity and integration into the community with assurance of the health and welfare of the waiver participant.

Identification of the waiver participant's strengths, abilities, and preferences are the starting point for developing the Service Plan. Each Service Plan will include an assessment of the individual to determine the services needed to prevent institutionalization. The assessment process is completed utilizing a multi-faceted approach which may include self-assessment, speaking with significant others, facilities that the waiver participant has had recent contact and the service providers.

The assessment includes exploring with the waiver participant:

- What are your (the waiver participant's) goals
- What can be done to help the waiver participant fulfill his/her goals
- How can the waiver participant be assisted to become a member of the community
- What can be done to assist the waiver participant to be more independent
- What are the waiver participant's concerns or fears

The Initial Service Plan (ISP) will include obtaining relevant information which will assist in clarifying the strengths and needs of the potential waiver participant. The planning process for a potential waiver participant who is being deinstitutionalized will include obtaining the final summary of care and the post discharge plan that were prepared by that facility. This will also include speaking with staff involved in a recent discharge from a hospital, affiliation with a home health care agency, a rehabilitation agency or others that are involved with the waiver participant. The Service Coordinator needs to have a full and accurate picture of the potential waiver participant's preferences including such areas as family, marriage, living situation, recreation or leisure time, physical and mental health, spiritual, vocation or job and community service. The assessment will include the following: demographic information, description of the individual in person centered terms, psycho-social history and a needs assessment. The assessment also includes an assessment of risk factors that will be addressed in the Plan for Protective Oversight. This will be discussed in greater detail in D-1(e).

The waiver participant first becomes aware of the available services through the interview process that was conducted by the RRDS at the time of the preliminary screening. The Service Coordinator is responsible for reviewing available waiver services and assisting the waiver participant to determine those services which will assist him/her to achieve his/her personal goals. The Service Coordinator is responsible for providing a list of all service providers and, if necessary, assisting the participant in selecting specific providers. If at any time the participant chooses to change service providers the Service Coordinator will assist the participant to select another provider. The Service Coordinator will present options for meeting the needs and preferences that the waiver participant has deemed to be important. The Service Plan is based primarily on the potential waiver participant's choice of services and providers, and reflects the potential waiver participant's dignity of risk and right to fail. The potential waiver participant will be afforded the opportunity to have family, friends or advocates participate in the development of the Service Plan. However, the request by a capable potential waiver participant that a representative does not participate in the planning process will be respected unless the representative is a guardian appointed by the court. The development of a Service Plan is not a stagnant process, but one that continues to evolve as the waiver participant requests revisions, experiences significant changes, or as new service options become available. The Service Coordinator is crucial to the waiver participants' success in the community, as they work with the waiver participant in the development, oversee the implementation, monitoring and evaluation of the Service Plan.

Each Service Plan that the Service Coordinator and the waiver participant complete will contain the type of waiver services, Medicaid State Plan and/or other services to be furnished, the amount, frequency and duration of each service, and the provider who will furnish each service. This part of the assessment of services will include an Individualized Service Plan (ISP) completed by each waiver service provider and provided to the Service Coordinator for inclusion in the Service Plan. The Service Plan is the essential tool that clearly states responsibility for each of the services and supports that the waiver participant needs based on a comprehensive, person centered assessment. The Service Plan is updated every six months, when there is a significant change in the participant's needs for support and services or his/her life situation, or when requested by a waiver participant. Additional information on Implementation and Monitoring of the Service Plans is in section D-2.

The Service Plan specifies all supports to be provided to the waiver participant, including: informal caregivers (i.e.

family, friends, and natural supports); federal and State funded services; Medicaid State Plan services; and waiver services. Waiver services are services that are provided when informal or other supports are not available to meet the participant's needs. Waiver services may also be accessed when the use of these services maybe more efficient or cost-effective than Medicaid State Plan services.

Further assessments of specific skills are included as a component of the activities associated with waiver services. If the waiver participant's level of skill changes, there will be an appropriate adjustment in the type and amount of the waiver services provided.

The Service Coordinator will assist the waiver participant in obtaining and coordinating the services that are outlined in the Service Plan. The Service Plan must reflect coordination between all providers involved with the waiver participant. It is also necessary to obtain input from the agencies other than waiver service providers that authorize and/or directly provide needed services. Some Medicaid funded services, such as personal care services (known as home attendant services in New York City), require prior authorization from the Local Department of Social Services.

Every Service Plan and Addendum also includes a signed Plan of Protective Oversight (PPO). The PPO address such factors as the individuals who are responsible for assisting the waiver participant with daily activities/emergencies, medication management, and financial transactions. Fire, safety issues and back-up plans are also included. The PPO is a system in place to reduce risk and address safety issues. The PPO addresses back-up issues for activities which are directly related to health and welfare.

The Service Plan must reflect that the waiver participant was actively involved in the development of the Service Plan. By signing the Service Plan, the waiver participant acknowledges that he/she has contributed to the development of the Service Plan, and agrees with its contents. The waiver participant and all waiver providers receive a copy of the approved Service Plan to assist with coordination of services. Prior to the development of a Revised Service Plan (RSP) at least every six months, all team members and the waiver participant attend a Team Meeting to review services, goals and accomplishments and assist the waiver participant in the develop a plan for the next six months.

RAI: The Service Coordinator has 60 calendar days from the date he/she begins working with the waiver applicant to develop an Initial Service Plan (ISP).

The TBI waiver does not use temporary or interim service plans to get services initiated until a more detailed service plan can be finalized. A temporary plan cannot assure a person's health and welfare in the community. A complete approved Service Plan that can be implemented at the time of discharge is necessary prior to consideration for discharge.

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.

The TBI waiver recognizes the waiver participant's dignity of risk and the right to fail, and balances this with the State's responsibilities to assure health and welfare and the waiver participant's right to select services and providers. It is critical to obtain an accurate picture of what services and supports might be needed to maintain the health and welfare of the waiver participant. Through the development of the Service Plan, which includes the Detailed Plan completed by each waiver service provider, a comprehensive understanding of the waiver participant's level of skills is obtained. This provides the background to understand the areas of activities which may present risks to the waiver participant. The extent of that risk is also evident. Each waiver service provider is responsible for providing feedback to the waiver participant. Every effort is made to assist the waiver participant to understand his/her risks that may be associated with his/her performance of Activities of Daily Living (ADLs) and Independent Activities of Daily Living (IADLs). The waiver participant has the right to accept or reject assistance with or modifications to these activities.

There may come a point when the waiver participant's choices are such that the waiver program becomes concerned that it will not be able to assure the waiver participant's health and welfare. This concern is clearly discussed with

the waiver participant. If the waiver participant's health and welfare can be assured, then the waiver participant can remain in the waiver. If this is not possible, then the waiver participant is issued a Notice of Decision, indicating discontinuance from the waiver, with Fair Hearing rights attached.

Every Service Plan and Addendum also includes a signed Plan of Protective Oversight (PPO). The PPO indicates activities that directly impact the health and welfare of the participant and clearly identifies the individual(s) responsible for providing the assistance. The PPO is included in each ISP, RSP and Addendum and is signed and dated by all the individuals listed as supports to the waiver participant. Areas that may be addressed in the PPO include assisting the waiver participant with daily activities, medication management, and financial transactions. Fire, safety issues and back-up plans are also included. The PPO is a system in place to reduce risk and address safety issues. The PPO addresses back-up issues for activities which are directly related to health and welfare. The Service Coordinator is responsible for assuring that the activities outlined in the PPO are carried out and are sufficient.

Participant risk and safety considerations are identified and potential interventions considered that promote independence and safety with informed involvement of the waiver participant.

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 waiver participant has the right to select a new provider at any time during the period covered by an approved Service Plan. They are informed of this right during the initial interview with the RRDS, during an annual review and signing of Waiver Participant Rights Form and periodically by the Service Coordinator but at a minimum every six months with the development of a revised Service Plan.

The RRDS is responsible for providing the waiver participant with a list of Service Coordinators and encourages them to select one based on an interviewing process.

The Service Coordinator is responsible for ensuring that waiver participants sign a Service Selection form during the application process, indicating that they have been informed of all approved providers within their region. In the Participant Rights Form, which is signed annually, there is a description of the right to choose and change waiver service providers, as requested by the waiver participant. The Service Coordinator is responsible for assuring that the waiver participant knows about his/her ability to choose or change waiver service providers and assist the waiver participant to do so. There is a process and forms developed to facilitate transition to a new provider.

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):

There is a multi-tiered approach to ensuring the quality of Service Plans. The first review is conducted by the RRDSs of all Service Plans, developed at least every six months, at the request of the waiver participant or as needed. This review is to assure that waiver services are being utilized appropriately, maintain the waiver participant's health and welfare and are cost-effective.

The second-level of intervention is conducted by the Clinical Consultant who reviews every Service Plan costing an amount established by DOH. The Clinical Consultant will conduct a retrospective random sampling, of at least five-percent (5%) of all Service Plans. This review includes a review of services, the maintenance of the participant's health and welfare, and cost efficiency of the Service Plan. These reviews are tracked and reported to DOH Waiver Management staff each quarter. Any immediate concerns are shared with DOH staff at the time the review is conducted.

In addition, the DOH Waiver Management Staff reserves the right to review any Service Plan presented to the waiver program.

RAI: The TBI Clinical Consultant does a 10% retrospective review across the State each year. If the DOH Waiver Management Staff identify the need for the Clinical Consultant to further review the quality of Service Plans in particular regions, the Clinical Consultant also conducts additional retrospective reviews upon request.

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:

- 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 §74.53. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Regional Resource Development Specialist

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.

Once the Service Plan has been approved by the RRDS, the Service Coordinator is responsible for monitoring the implementation of the Service Plan and the waiver participant's health and welfare. The Service Coordinator will have monthly face to face meetings with the waiver participant to assure that the services are meeting the waiver participant's needs and that the waiver participant is satisfied with the services being provided. A Team Meeting can be called at any time by the Service Coordinator or other providers of waiver or non-waiver services, and at the request of the waiver participant. The purpose of this Meeting is an opportunity to allow for collaboration among the service providers and the waiver participant regarding the waiver participant's current needs and to ensure the health and welfare of the waiver participant. A Team Meeting is required when the Service Plan is revised every six months.

In addition to this, the RRDS is responsible for the review and approval of every Service Plan, Revised Service Plan and Addendum to assure they are meeting the waiver participant's health and welfare and that they are cost-effective. Service Plans costing over an amount established by DOH are then also reviewed by the Clinical Consultant.

Service Coordinators assist waiver participants in developing Service Plans that include services from a variety of sources. The TBI waiver is built on the premise that all waiver participants will first utilize available informal/natural supports, available non-Medicaid community-based services, available Medicaid State Plan services and, finally, TBI waiver services. TBI waiver services are utilized as a last resort to eliminate any gaps in assuring

the participant's health and welfare in the community or when the TBI waiver services are more effective than Medicaid State Plan services.

Once the Service Plan is developed, the Service Coordinator is then responsible for monitoring the implementation of the Service Plan, including waiver participant access to non-waiver services such as vocational services, physician services, home care services available through the Medicaid State Plan and other non-Medicaid community-based services. For example, the Service Coordinator is responsible for ensuring that the waiver participant obtains follow-up medical care, if needed, and that the waiver participant attends routine medical appointments.

The methodology used to monitor the Service Plans, which include informal/natural supports, non-Medicaid community-based services, Medicaid State Plan services and TBI waiver services, includes the Service Coordinator collaborating with the waiver participant, other interested parties and service providers. The Service Coordinator will have monthly face to face meetings with the waiver participant. The Service Plan can be revised with an Addendum if needed, as a result of changes in the waiver participant's condition or situation. The RRDS can also meet, as needed, with the team to discuss the provision of services and will monitor Service Plans. The RRDS will report any major problems that affect a waiver participant's health and welfare in their quarterly report to DOH Waiver Management Staff or contact DOH Waiver Management Staff and/or the Clinical Consultant for technical assistance on major problems. Finally, the Clinical Consultant retrospectively reviews a random sample of Service Plans. The Clinical Consultant will report to DOH Waiver Management Staff the information received from these monitoring processes and the analysis of their findings in the Clinical Consultant quarterly reports. DOH Waiver Management Staff will inform the RRDS and Clinical Consultant regarding any follow-up interventions that are needed at the provider, regional or statewide level.

In addition, each waiver service provider agency, as required in the TBI waiver program manual, must conduct their own participant satisfaction survey to ascertain the experiences of the waiver participants that they serve. The Service Coordinator will work with the waiver participant to remedy any problems that are identified.

Monitoring of the Service Plan is also done through the Incident Reporting process. All Serious Reportable Incidents are reported to the Service Coordinator, the RRDS and the Clinical Consultant. When a Serious Reportable Incident involves issues affecting the waiver participant's health, such as unplanned hospitalizations or medication errors or refusals, follow-up will include the Service Coordinator working with the waiver participant to review the Service Plan to see if an Addendum or Revised Service Plan is necessary. The Clinical Consultant will include data on Serious Reportable Incidents in their quarterly report to DOH Waiver Management Staff.

RAI: The Service Coordinator is required to have a face-to-face visit with each waiver participant at least monthly and once every six months this visit must be made in the participant's home. During this visit, the Service Coordinator is required to review the services in place, whether they continue to be effective and appropriate, and the participant's satisfaction with these services. The Team Meeting, which is required every 6 months prior to submittal of a revised service plan, does not meet this monthly face-to-face requirement.

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:*

While the agency (entity) that employs the Service Coordinator may provide other direct waiver services, an individual Service Coordinator can only provide Service Coordination to an individual and is prohibited from providing other direct waiver services to that individual.

All waiver participants have a choice of their waiver service providers. At anytime, the waiver participant can change their waiver service providers, including Service Coordinators. If a waiver participant chooses to change a waiver service provider, a Change of Provider form must be completed. This change must be reviewed and approved by the RRDS.

Annually, the Service Coordinator reviews the Participant's Rights Form with each waiver participant, which includes the right to choose and change providers as requested by the waiver participant. Waiver participants sign and maintain a copy of the signed form.

The safeguards previously described are implemented from the start of the ISP to assure the services are being provided according to the Service Plan. As stated above, every RRDS reviews and approves every Service Plan.

Other safeguards will include a Recordable Incident Report; a Serious Reportable Incident Report; a toll-free TBI waiver Complaint Line; the provision of a Provider Contact List to the waiver participant containing the phone numbers for the providers and their supervisor's, the RRDS, and the TBI Complaint Line; annual DOH surveys and audits, and retrospective reviews by the Clinical Consultant. Waiver participant satisfaction surveys are conducted by providers, and reviewed by the survey component of DOH upon survey. Appropriate concerns are reported to DOH Waiver Management Staff for follow-up.

The Service Coordinator has the dual role of developing and monitoring the Service Plan. In order to ensure monitoring is conducted in the best interest of the waiver participant there are checks and balances in place as described in Appendix D-1-b. The Service Coordinator is also monitoring waiver participant satisfaction throughout interaction with the waiver participant. This is documented in the Service Coordinator's records and will be examined upon survey or upon any complaints made by the participant or legal guardian. In addition, the RRDS provides oversight, technical assistance and reviews and approves every Initial and Revised Service Plan to assure the health and welfare of the waiver participant and their right to choice of providers. The Clinical Consultant also reviews Service Plans costing over an amount established by DOH and other Service Plans as necessary. DOH Waiver Management Staff can also review any Service Plan, whether it be random or targeted.

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

APPENDIX E-1 (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 (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-2: OPPORTUNITIES FOR PARTICIPANT DIRECTION

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.

During the initial face-to-face meeting between the RRDS and the potential waiver participant, the RRDS provides

information regarding the Notice of Decision form, the Conference and the Fair Hearing processes. The Service Coordinator (SC) ensures that the potential waiver participant understands his/her rights as they proceed through the process of determining the applicant/participant of their eligibility to be enrolled in the waiver program and throughout the duration of their participation. Notice of Decision authorizing participation in the waiver program is provided by the RRDS to the participant, which includes Fair Hearing rights.

At the time of the screening for eligibility to participate in this waiver, the Regional Resource Development Specialist (RRDS) will inform the potential participant of his/her option of receiving services in a nursing facility through the waiver or other appropriate waivers or State Plan services. The individual will also be advised of his/her fair hearing rights. This will be documented in the form provided. This form will be maintained at the screening agency. A copy of this form will also be maintained in the file of the service coordinator for individuals who decide to participate in the waiver.

The following is a list of the notices utilized to inform the applicant/participant of his/her rights to a Fair Hearing:

- a. A copy of the form(s) used to document Freedom of Choice and inform the applicant/ participant of their right to a fair hearing;
- b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
- c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
- d. A description of how the individual (or legal representatives) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.
- e. Potential Participant Acknowledgement
- f. Participant's Rights and Responsibilities

When an applicant/participant seeks review of an RRDS' action or determination regarding their waiver services under home and community-based services (e.g. denials, decrease and discontinuance) a Notice of Decision is sent to the applicant/participant (or his/her legal guardian) by the RRDS which includes detailed, easy-to read instructions about the right to request a Conference and/or a Fair Hearing, and the process for applying for either. The participant or his/her legal guardian is also informed that requesting a Conference is not a prerequisite/or substitute for a Fair Hearing. The RRDS provides a copy of the Notice of Decision to the Service Coordinator, who is responsible for reviewing the form with the participant and /or legal guardian to assure understanding of the right to request a Conference or Fair Hearing. In addition, the SC reviews information regarding the participant's right to continue services during the period while the participant's appeal is under consideration, as noted in the Notice of Decision. A copy of the Notice of Decision with the Conference and Fair Hearing information is kept in the individual's record maintained by the RRDS and Service Coordinator. This process conforms to the Federal and State statutory and regulatory provisions of the Medicaid program.

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:

DOH Waiver Management Staff is responsible for overseeing the operation of the grievance complaint system developed and operated by the contracted not-for-profit entity, Brain Injury Association of New York State, Inc. (BIANYS).

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).

The TBI waiver mandates that each waiver service provider develops and implements a policy for responding to complaints/grievances raised by the waiver participant. These policies must include procedures for filing the complaint/grievance, the process for investigation, and documentation of outcomes. In addition, any changes in agency policies and procedures related to the outcome of the investigation must be recorded and implemented. Each investigation must be conducted confidentially meeting the standards set by Health Insurance Portability and Accountability Act (HIPAA). Waiver participants are informed by the RRDS and Service Coordinator that filing a grievance/complaint is not a pre-requisite or substitute for a Conference or Fair Hearing and they may do so without jeopardizing the provision of services established in their service plan. A Participant Rights Form is reviewed and signed yearly by the waiver participant.

A waiver participant may file a grievance/complaint through other mechanisms. These include providing a written or verbal complaint to any staff person associated with the waiver program. In addition, DOH, BMLTC has contracted with the not-for-profit entity, Brain Injury Association of New York State, Inc. (BIANYS) to develop and operate a statewide toll-free telephone information and resource service and expand outreach and public education efforts to consumers, families, providers, and professionals for the purpose of increasing access to the toll-free helpline and informational resources, known also as "Family Helpline." In addition, the State funds a toll-free complaint line for waiver participants and their family members. BIANYS is in the process of developing a computerized database for tracking information and referrals, outreach and other requests for information.

The helpline and complaint line provide the central points for complaints about waiver services. The complaints are logged and transmitted to DOH through agreed upon protocols.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. 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).

Type of incidents: Serious Reportable Incidents, Recordable Incidents

A. SERIOUS REPORTABLE INCIDENT is defined as any situation in which the waiver participant experiences a perceived or actual threat to his/her health and welfare or to their ability to remain in the community. These incidents include:

-Allegations of physical, sexual and psychological abuse, seclusion, unauthorized or inappropriate use of restraints, use of aversive conditioning, violation of civil rights, mistreatment and neglect, exploitation

-Missing person

-Death of a waiver participant

-Unplanned hospitalization

-Possible criminal action

-Medication error/refusal

-Medical treatment due to accident or injury

-Sensitive situation is any situation that does not fit within the above categories, which needs to be brought to the attention of the RRDS that would potentially threaten the waiver participant's health and welfare or ability to remain in the community, such as an admission into a substance abuse or psychiatric facility.

a. Follow up and Time Frame of a Serious Reportable Incident to the TBI waiver:

1. The waiver provider discovering that an alleged Serious Reportable Incident has occurred (the reporting waiver provider) must report the alleged incident to the responsible RRDS within 2-hours of the discovery by telephone followed by fax or email using the Initial Provider Report. If the Service Coordination agency is not the reporting agency, a copy of this report should also be sent to the Service Coordinator within 2 hours of the discovery.
2. The reporting waiver provider is responsible for completing the 24-hour Provider Report and sending it via fax or mail to the RRDS within 24-hours of discovering the incident. If the Service Coordination agency is not the reporting waiver provider a copy of the report must also be faxed or mail by the reporting agency to the Service Coordinator within the same time frame. The Service Coordinator is responsible for notifying the waiver participant and/or their legal guardian within 24-hours of receiving the report that an incident has been reported and is being investigated. The Service coordinator is also responsible for notifying other program or waiver providers of the incident when the evidence of injury or incident may impact services or the waiver provider. In the case of a waiver participant's death, the reporting agency will also provide a copy of the 24 hour Provider Report to DOH Waiver Management Staff within 24-hours of reporting the death. The RRDS will assure DOH Waiver Management Staff has received a copy of the report. The RRDS will notify DOH Waiver Management Staff when the seriousness of an alleged incident is at such a level to cause concerns about the possibility of a programmatic impact. The RRDS will keep an Incident Report database to be reported to DOH Waiver Management Staff on a quarterly basis or as necessary, per severity of incident. When it is deemed appropriate to contact Adult Protective Services (APS) as part of the investigation, the RRDS will assure this was done. In addition, waiver policy indicates notification to the police if any criminal action occurs. Any entity involved in the investigation process may initiate contact with APS or the police. All contacts with APS and/or the police must be documented as part of the investigation process.
3. Upon receipt of the 24-hour Provider Report, the RRDS reviews it within 24-hours and completes the RRDS Initial Response form, assigning an incident number to the case. The RRDS assigns responsibility for the investigation usually to the provider alleged to be involved in the incident (investigating waiver provider). If the RRDS is concerned that the investigating waiver provider is not in a position to conduct an objective, thorough investigation, the RRDS has the discretion to assign another waiver provider to conduct the investigation.
4. The investigating waiver provider must designate at least one individual to be responsible for conducting a thorough and objective investigation. The investigator is required to have experience and/or training in conducting investigations. Those conducting the investigation may not be: directly involved in the incident; an individual whose testimony is incorporated in the investigation; or individuals who are the supervisor, supervisee, spouse, significant other or immediate family member of anyone involved in the investigation.
5. The investigating waiver provider is responsible for contacting their Serious Incident Review Committee to initiate their involvement in the investigation process.
6. Within seven (7) calendar days of receiving the 24-Hour Provider Report and the RRDS Initial Response forms, the investigating waiver provider must submit a Provider Follow Up Report to the RRDS and Service Coordinator.
7. Within fourteen (14) calendar days of receipt of the investigating waiver provider's Follow-Up Report; including the agency's Serious Incident Review Committee's documentation, the RRDS must complete the RRDS Status Report indicating whether the case is considered closed or still open. The RRDS may make recommendations for further investigative action. The RRDS forwards a copy of the RRDS Status Report to the Service Coordinator and the investigating waiver provider.
8. If the RRDS determines on the RRDS Status Report that the incident is to remain open, the investigating waiver provider must submit the Provider Follow-up form to the RRDS and the Service Coordinator, within thirty (30) calendar days of the 24-Hour RRDS Initial Response forms. This Follow up Report includes documentation from the waiver provider's Serious Incident Review Committee's response to the investigation.
9. If the incident is considered to be open, continued follow-up and investigation by the investigating provider is expected. A DOH Serious Reportable Incident Follow-Up Report must be submitted monthly by the anniversary date of the discovery of the incident by the investigating provider to the RRDS. These monthly reports will continue until corrective actions assure that the investigating waiver provider has put in place policy and procedures which will significantly decrease the probability of this type of incident recurring and the RRDS declares the incident closed. The RRDS will forward a copy of the report to the investigating provider agency and the Service Coordinator.

10. Once the incident is deemed closed, the RRDS sends the RRDS Status Report to the investigating provider and Service Coordinator.

11. The RRDS may request technical assistance/guidance from the DOH Waiver Management staff at any time and may request clinical assistance from the Clinical Consultant, Neurobehavioral Project at any point during the investigation.

Who must report a Serious Reportable Incident:

Any employee of a waiver provider witnessing any action or lack of action that may constitute a Serious Reportable Incident as described above is responsible for initiating the process for investigation. It is understood that in some cases the employee may need to notify their supervisor and that the supervisor may be the person to notify the RRDS and the Service Coordinator. However, it still remains the responsibility of the employee that witnesses the incident to complete the DOH Serious Reportable Incident Initial Provider Report.

If no waiver provider employee witnessed the incident, the employee who first becomes aware of the incident must notify their supervisor upon discovery. The supervisor must notify the RRDS within two hours of the discovered alleged incident. The employee or their supervisor will initiate the DOH Serious Reportable Incident Initial Provider Report Form. Then the DOH Serious Reportable Incident 24-Hour Provider Report is completed and forwarded to the RRDS within 24 hours of discovery by the provider.

B. A RECORDABLE INCIDENT is defined as incidents that do not meet the level of severity as a Serious Reportable Incident but impacts the waiver participant's life in the community. Examples of Recordable Incidents are falls that do not require medical attention and minor difficulties in money management. These incidents must be reported, investigated and tracked within the provider agency.

a. Each waiver provider agency will have policies and procedures regarding Recordable

Incidents including the following:

-title or position of the individual(s) responsible for implementing these policies;

-process for reporting, investigating and resolving Reportable Incidents within the agency

-process for identifying patterns of incidents involving a specific participant or staff within the agency that threaten the health and welfare of participants in general

-system for tracking the reporting, investigating and outcome of all Recordable Incidents and recommending action for changes in policy and procedures

-criteria used to determine when a Recordable Incident should be upgraded to a Serious Reportable Incident and reported to DOH Waiver Management Staff.

Each agency's Serious Incident Review Committee must submit an annual report to the RRDS regarding reportable incidents, and allegations of waiver providers and corrective, preventive and/or disciplinary action pertaining to identified trends. This report must include the name and position of each of the members of the committee and documentation of any changes in the membership during the reporting period. The RRDS reviews these reports and submits to DOH. In addition, DOH may request a copy of these reports at any time.

DOH Waiver Management Staff reserves the right to review Recordable Incident reports at any time.

b. 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.

The waiver applicant first receives information concerning protections from abuse, neglect and exploitation during the initial interview with the RRDS. The RRDS informs the applicant, family and legal guardian of the Complaint line, the philosophy of the waiver and participants rights and receives the RRDS phone number.

The Service Coordinator will provide the waiver participant, their family or legal guardian information to identify actions described as abuse, neglect and exploitation and other types of serious reportable incidents along with the process for reporting any perceived or actual threat to his/her health or welfare or their ability to remain in the community. The Service Coordinator will provide: the waiver participant, their family or legal representative with the Waiver Participant's Rights; a Waiver Contact list including the name, title, phone number and address of all providers, in addition to all information on how to contact the RRDS, and the toll-free TBI Waiver Complaint Hotline.

The Service Coordinator will assist the waiver participant with completing the Plan of Protective Oversight.

The Service Coordinator will provide the above information to the waiver participant at the time of the development

of the Initial Service Plan, every six months during the development of the Revised Service Plan, and when the waiver participant's health and welfare are noted as being at risk and additional education is necessary. It is the responsibility of the Service Coordinator to assist the participant to resolve concerns and complaints about services and service providers. The participant may receive additional support and direction from the RRDS and DOH waiver management staff as desired or in the event that the Service Coordinator is not successful in resolving concerns and complaints about services and service providers. All waiver providers are responsible for protecting and promoting the ability of the participant to exercise all rights identified in the Waiver Participants Rights form.

All participants receive a refrigerator magnet with the Complaint line phone number and email.

RAI: Service Coordinators are required to meet with participants monthly to review waiver services and discuss any potential issues with the waiver. Every six months when Revised Service Plans are due, Service Coordinators are also required to review the Participants Rights and Responsibilities form with participants. The RRDSs also meet with participants, their service providers, as well as their family members if applicable, every six months in team meetings to review Service Plans. The participants have the opportunity to raise questions or concerns regarding their services or the waiver program during team meetings.

The TBI Best Practice Symposium, an annual conference designed for participants and their caregivers, provides many workshops regarding waiver services for waiver participants. This year's conference, for example, will include a session on participants Rights and Responsibilities and a Q&A session on the TBI waiver program.

The TBI waiver program is currently in the process of developing a user-friendly participant manual on the waiver program. The manual's design will incorporate features recommended by TBI waiver participants and is coordinated by the Neurobehavioral Project. This is expected to be an ongoing project of the Neurobehavioral Project.

The TBI waiver program also has a contract with the Brain Injury Association of New York State (BIANYS). The contract provides a toll-free Help Line, as well as funding to hold an annual two-day conference held by BIANYS for people with brain injury and their family members. Each year, the TBI waiver program does a presentation on the TBI waiver program and a Q&A session at this conference.

- c. 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.

The entities that receive reports of critical events or incidents specified in G-1a include the investigating agency and their Serious Incident Review Committee, the RRDS, the Service Coordinator, the Clinical Consultant, DOH Waiver Management staff, DOH provider survey component and TBI Complaint line. Contact may be initiated with Adult Protective Service (APS) or the police by any entity involved in an investigation when it is deemed appropriate. Reports from these agencies are included in any investigative report from the investigating waiver provider.

Investigating agency and their Serious Incident Review Committee

The individual who witnesses a Serious Reportable Incident (SRI) is responsible to notify their supervisor, the RRDS and the Service Coordinator (SC) within 2 hours of the incident with a follow up report within 24 hours to the RRDS and the SC. In the case of an unexpected death of a waiver participant, DOH waiver management staff are also notified within these timeframes as outlined in section G-1-a.

If the reporting waiver provider is not the agency involved in the investigation, the RRDS must notify the investigating waiver provider and the Service Coordinator as soon as he/she receives notification of the incident.

The investigating waiver provider is responsible for notifying their Serious Incident Review Committee that an investigation has been initiated and their involvement is required. The investigating waiver provider must designate at least one individual to be responsible for conducting a thorough and objective investigation. The investigator is required to have experience and/or training in conducting investigations. Those conducting the investigation may not be directly involved in the incident, an individual whose testimony is incorporated in the investigation, or individuals who are the supervisor, supervisee, spouse, significant other or immediate family member of anyone involved in the investigations.

The CC has developed training programs regarding Serious Reportable Incident Policy and Procedures and a separate training for SRI investigators. This program is available state wide to any provider agency and has been presented at the annual Best Practice Conference. Content of the training includes how to interview, gather information, document evidence, analysis of the information and development of conclusion and recommendations.

Waiver providers are required to have a Serious Incident Review Committee, which meets at least quarterly and always within one-month of a report of a Serious Reportable Incident. The Committee will review all Serious Reportable Incidents to assure that incidents are appropriately reported, investigated and documented and that final recommendations are in line with the best clinical practice and in compliance with the guidelines of the TBI waiver. The Committee also assures that the waiver provider's Serious Incident Reporting policies and procedures comply with DOH TBI Incident Reporting Policies. This Committee will determine if necessary and appropriate corrective, preventive and/or disciplinary actions has been taken, develop recommendations for changes that may prevent or minimize recurrence of the incidents, and identify trends in Serious Reportable Incidents. In addition, the Committee will review all Recordable Incidents.

The Serious Incident Review Committee prepares an annual report that includes all Serious Reportable Incidents and Recordable Incidents reviewed by the Committee throughout the year. The report is submitted to the RRDS who reviews the report and forward it to the DOH Waiver Management Staff for review. This report will show congruity between the number of Serious Reportable Incident reports received by Clinical Consultant and the number of reports claimed by the waiver provider. In addition, data from the report will assist DOH Waiver Management Staff in identifying trends, and whether corrective, preventive and/or disciplinary action pertaining to identified outcomes was successfully implemented. Also, data from the report will be used to evaluate whether further waiver provider training and educational programs are needed and to determine if systemic actions need to be taken.

The Committee will review all Serious Reportable Incidents to assure that incidents are appropriately reported, investigated and documented and that final recommendations are in line with the best clinical practice and in compliance with the guidelines of the TBI waiver. The Committee also assures that the waiver provider's Serious Incident Reporting policies and procedures comply with DOH TBI Incident Reporting Policies. This Committee will determine if necessary and appropriate corrective, preventive and/or disciplinary actions had been taken, develop recommendations for changes that may prevent or minimize recurrence of the incidents, and identify trends in Serious Reportable Incidents. In addition, the Committee will review all Recordable Incidents.

The RRDS and the Service Coordinator

The RRDS receives a report of a SRI from a reporting waiver provider within 2 hours and a follow up report within 24 hours as outlined in G-1-a. Copies of this report are also forwarded to the Service Coordinator from the reporting waiver provider.

RRDS continues to receive reports from the investigating waiver provider seven (7) calendar days after sending the RRDS Initial Response to the investigating waiver provider. The investigating agency is required to submit follow up reports to the RRDS and Service Coordinator at least every 30 days from the anniversary of the initial incident report until the RRDS determines that the case is closed. The RRDS notifies the investigating waiver provider of the status of the investigation (open or closed) and provides comments, suggestions and requests for additional information or actions on the part of the investigating waiver provider regarding the investigation using the RRDS Status Report. All communications regarding the report between the RRDS and the investigating waiver provider is also forwarded to the Service Coordinator. Once the case is determined by the RRDS to be closed, a final RRDS Status Report will be completed and sent to the Service Coordinator and investigating provider by the RRDS.

The RRDS may request technical assistance from the DOH Waiver Management Staff, at any time. DOH may request clinical expertise and/or involvement of the Clinical Consultant, or the Neurobehavioral Project at any point during the investigation. In sensitive situations, DOH may request an investigation to be conducted by the Clinical Consultant.

Clinical Consultant(CC)

The RRDS submits a quarterly report to the CC reporting the status of all the new or open incidents. The Clinical Consultant keeps records on all incidents within the state in that calendar year. Quarterly, the Clinical Consultant conducts a trend analysis on a regional and state-level and submits an annual report to the Waiver Management Staff. As part of the quality management process, the Clinical Consultant also conducts an analysis on incidents that are repeating in nature, whether in provider agency or in participants and submits the analysis to the Waiver Management Staff on a quarterly basis. The report may also include recommendations to DOH for quality improvements, training needs and policy changes etc., based on the findings.

DOH Waiver Management Staff

If a death of a waiver participant occurs, DOH waiver management staff will receive notification within 2 hours of discovery of the incident and receive a copy of the 24 hours SRI report. The RRDS may consult the DOH Waiver Staff for technical assistance and DOH may request clinical assistance from the Neurobehavioral Project and

Clinical Consultant (CC) if indicated.

The RRDS and the Clinical Consultant provide quarterly reports to DOH Waiver Management Staff of all Serious Reportable Incidents for their region containing documentation regarding trends, severity of incidents, the status and the outcome of the investigations. The Clinical Consultant reviews the data for regional and statewide trends and makes recommendations for needed interventions to the DOH Waiver Management Staff. Through the RRDS awareness of incidents and trends they can provide technical assistance to the providers, question the viability of providers and make recommendations on a regional and system-wide basis. Additionally, DOH Waiver Management Staff analyzes the data for state-wide trends that may warrant changes in the TBI Waiver program. RRDS, the Clinical Consultant and DOH Waiver Management Staff maintain close communication regarding the management of issues raised through investigations.

The TBI Waiver Management Staff, the RRDS and the Clinical Consultant have the authority to investigate the conduct, performance and/or alleged neglect of duties of administrators or employees of any waiver provider or individual serving as a waiver provider. This level of intervention occurs when there are concerns that the waiver provider has not followed the procedures of this policy. Findings are reported to DOH Waiver Management Staff. If the waiver provider is found to be noncompliant with these policies, DOH Waiver Management Staff will take appropriate action that may include terminating the Provider Agreement.

DOH survey staff

During survey of waiver providers, the survey component of DOH will evaluate processes to assure the waiver providers have complied with all policy/procedures regarding incidents, incident committee and reporting timeframes. The Survey staff will notify DOH Waiver Management Staff immediately if concerns are identified regarding a particular waiver provider's practices. The waiver provider is issued a notice of deficiencies and must submit a Plan of Correction to the DOH survey staff. DOH Waiver Management Staff reserves the right to review how successful a waiver provider has been in incorporating and utilizing any changes in the waiver provider's policy and procedure in regards to recommendations related to investigations.

TBI Complaint Line

Waiver participants may contact the toll free Complaint line to report concerns, complaints or potential violations in their rights. These complaints are forwarded to DOH Waiver Management staff and forwarded to the RRDS for investigation and response. Some of these complaints may be determined by DOH or RRDS to be a SRI and would then follow the policies, procedures and time frames outlined in G-1-a of this section.

DOH Waiver Management Staff works cooperatively with other State agencies that provide services to individuals with disabilities, informing them when mutual providers experience significant or numerous Serious Reportable Incidents.

RAI: The Serious Reportable Incident Review Committee for each provider agency is comprised of either agency-wide, multi-program personnel or waiver program-specific personnel. Independent HCBS/TBI waiver providers must also form a committee to review serious incidents. One way to accomplish this is to partner with other independent providers or existing agencies.

The Committee must contain at least five individuals. Participation of a cross section of staff, including professional staff, direct care staff and at least one member of the administrative staff is strongly recommended.

The Executive Director of the agency shall not serve as a member of the Committee, but may be consulted by the Committee in its deliberations.

The Program Administrator may be designated as a member only if the Committee is an agency-wide or multi-program committee.

- d. **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.

Agencies responsible for overseeing the reporting of and response to critical incidents include DOH Waiver Management staff and/or contract agencies, and DOH survey team

DOH waiver Management staff

Receive quarterly reports of serious reportable incidents from the RRDS and the Clinical Consultant as stated in G-1-c.

On a quarterly basis, the RRDS will submit quarterly report to the Clinical Consultant and DOH Management Staff regarding the the status of all the new or open incidents. The RRDS provides a quarterly report to the Clinical Consultant and the DOH Waiver Management Staff of all Serious Reportable Incidents for their region containing documentation regarding trends, severity of incidents, the status and the outcome of the investigations. Each quarter, the Clinical Consultant reviews the data for regional and statewide trends and makes recommendations for needed interventions to the DOH Waiver Management Staff. Through the RRDS awareness of incidents and trends they can provide technical assistance to the providers, question the viability of providers and, make recommendations on a regional and system-wide basis. Additionally, DOH Waiver Management Staff analyzes the data for state-wide trends that may warrant changes in the TBI Waiver program. RRDS, the Clinical Consultant and DOH Waiver Management Staff maintain close communication regarding the management of issues raised through investigations.

Contract Agenceis

As part of the quality management process the Clinical Consultant keeps records on all serious reportable incidents within the state in the calendar year. Each quarter the Clinical Consultant conducts a trend analysis on a regional and state-level including an analysis on incidents that are repeating in nature, whether in provider agency or in participants and submits the analysis to the DOH Waiver Management Staff. The Clinical Consultant will also make recommendations to DOH for quality improvements, policy change, training needs based on the findings.

The TBI Waiver Management Staff, the RRDS and the Clinical Consultant have the authority to investigate the conduct, performance and/or alleged neglect of duties of administrators or employees of any waiver provider or individual serving as a waiver provider. This level of intervention occurs when there are concerns that the waiver provider has not followed the procedures of this policy. Findings are reported to DOH Waiver Management Staff. If the waiver provider is found to be noncompliant with these policies, DOH Waiver Management Staff will take appropriate action that may include terminating the Provider Agreement.

DOH survey staff

The survey component of DOH has responsibility to review records of a waiver provider to ensure adherence to reporting and recording policies including these regarding recordable and reportable incidents. The survey also includes are review of the presence and activities of the Serious Reportable Incident Committees to assure the waiver providers have complied with recommended changes in policy/procedures. DOH Waiver Management Staff may be called upon when there is concern regarding a particular waiver provider's practices. DOH Waiver Management Staff reserves the right to review how successful a waiver provider has been in incorporating and utilizing any changes in the waiver provider's policy and procedure in regards to recommendations related to investigations.

DOH Waiver Management Staff works cooperatively with other State agencies that provide services to individuals with disabilities, informing them when mutual providers experience significant or numerous Serious Reportable Incidents.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one):*

- The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

Unauthorized use of restraints or seclusion may be identified by the Department of Health waiver management staff, their contractors and the DOH survey teams.

Restraint in the TBI waiver program is defined as the act of limiting or controlling a person's behavior through the use of any device which prevents the free movement of any limb as ordered by a physician; any device or medication which immobilizes a person, as ordered by a physician; any device which is ordered for the expressed purpose of controlling behavior in an emergency; or any medication as ordered by a physician which

renders the participant unable to satisfactorily participate in services, community inclusion time or other activities.

This does not preclude the use of mechanical supports to provide stability necessary for therapeutic measures such as immobilization of fractures, administration of intravenous fluids or other medically necessary procedures.

Responsible State agencies include DOH waiver management staff and contractors, DOH survey staff,

RRDS as contractor for DOH

Any individual or waiver provider witnessing the unauthorized use of restraints - mechanical or medical - that is not specified in the participant's service plan and ordered by a physician, is required to report this incident as a serious reportable incident in accordance with the SRI policies and procedures. Investigation and resolution of the incident would follow the serious reportable incident procedures and time frames outlined in Appendix G-1-a. The RRDS may request technical assistance from the DOH Management staff and DOH may request clinical assistance from CC or State Neurobehavioral Project at any time.

RRDS conduct random face to face and phone surveys with waiver participants to assess participant satisfaction. If situations of unauthorized use of restraints or seclusion are reported the RRDS will assign an investigating agency to the situation and track as a SRI.

RRDS may contact DOH management staff at any time during a SRI for technical support and DOH may request involvement of Neurobehavioral Project or CC if appropriate. Unauthorized use of restrictive interventions is a SRI and is handled in accordance to SRI procedures.

DOH waiver management staff

DOH management staff can be informed of unauthorized use of restraints or seclusion through several ways, including the RRDS Serious Reportable Incident reports forwarded quarterly by RRDS and CC to DOH; results of random face to face and phone surveys conducted by RRDS or CC to waiver participants to determine participant satisfaction, information received from the TBI Complaint line, and DOH survey staff.

DOH may request random surveys of waiver participants to be conducted by the CC in sensitive situations when there are concerns regarding services from a specific provider agency or from an individual provider. The CC will conduct a thorough investigation with interviews of the participants to determine any trends or unreported incidents. If any unreported incidents of unauthorized restraints or seclusion are identified, DOH and the RRDS will be notified and an investigation will be conducted following SRI policy, procedure and time frames.

Complaint Line

All complaints from the Complaint Line are forwarded to DOH the day they are received. The report includes the nature of the complaint, the waiver participant(s) involved and the provider agency if included in the complaint. The complaint is reviewed by DOH and forwarded to the appropriate RRDS for immediate attention. The RRDS must report outcome of the investigation into the complaint to DOH. Any complaints found to involve the use of unauthorized use of restraints becomes a SRI and follows the policy, procedures and time frames for a SRI.

DOH Survey Staff

DOH survey staff conduct an on-site record review of each waiver provider at least once every 3 years. This survey includes a review of recordable and reportable incidents, the Serious Incident committee, review and resolution of incidents by the Committee, and a random review of participant service plans and records. Any unreported incidents become part of a notice of deficiencies to the provider agency and DOH waiver management staff are notified. A plan of corrective action must be submitted to the DOH survey staff. The survey team is in close communication with DOH waiver management staff who may request an investigation of a waiver provider be conducted by the CC.

Any reports of unauthorized restraint from any of these sources will prompt an immediate investigation of the agency. Along with investigation into a specific incident the CC may conduct face to face or phone surveys with other participants to determine the extent of the problem.

The CC conducts and analysis of all statewide SRIs and reports findings, analysis and trends with recommendation if appropriate to DOH waiver management staff quarterly.

- **The use of restraints or seclusion 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 or Seclusion.** 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 or 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 restraints or 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-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

- 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:

State agencies responsible for detecting unauthorized use of restrictive interventions include DOH waiver management staff, contractors, and the DOH survey staff.

RRDS as contractor for DOH

Any individual or waiver provider witnessing the unauthorized use of restrictive interventions is required to report this incident as a serious reportable incident in accordance with the SRI policies and procedures. Investigation and resolution of the incident would follow the serious reportable incident procedures and time frames outlined in Appendix G-1-a. The RRDS may request technical assistance from the DOH Management staff and DOH may request clinical assistance from CC or State Neurobehavioral Project at any time.

RRDS conducts random face to face and/or phone surveys with waiver participants to assess participant satisfaction. If situations of unauthorized use of restrictive interventions are reported, the RRDS will assign an investigating agency to the situation and track as a SRI.

RRDS may contact DOH management staff at any time during a SRI for technical support and DOH may request involvement of Neurobehavioral Project of CC if appropriate. Unauthorized use of restrictive interventions is a SRI. The RRDS provides oversight to the SRI and determines when the investigation of the SRI is satisfactory and complete. All SRIs are reported to the DOH waiver management staff and CC quarterly.

DOH waiver management staff

DOH management staff can be informed of unauthorized use of restrictive interventions through several avenues including RRDS serious reportable incident reports forwarded quarterly by RRDS and CC to DOH; results of random face to face and/or phone surveys conducted by RRDS or CC to waiver participants to determine participant satisfaction, information received from the TBI Complaint line, and DOH survey staff.

DOH may request random surveys of waiver participants to be conducted by the CC for any reason including for reported sensitive situations, when there are concerns regarding services from a specific provider agency of from an individual provider. CC will conduct a thorough investigation with interviews to participants to determine any trends or unreported incidents. If any unreported incidents of unauthorized restraints or restrictive interventions are identified, DOH and the RRDS will be notified and an investigation will be conducted following SRI policy, procedure and time frames.

Complaint Line

All complaints from the Complaint Line are forwarded to DOH the day they are received. The report includes

the the nature of the complaint, the waiver participant(s) involved and the provider agency if included in the complaint. The complaint is reviewed by DOH and forwarded to the appropriate RRDS for immediate attention. The RRDS must report outcome of the investigation into the complaint to DOH. Any complaints found to involve the use of unauthorized use of restraints becomes a SRI and follows the policy, procedures and time frames for a SRI.

DOH Survey Staff

DOH survey staff conduct an on-sight record review of each waiver provider at least once every 3 years. This survey includes a review of recordable and reportable incidents, the Serious Incident committee, review and resolution of incidents by the Committee, and a random review of participant service plans and records. Any unreported incidents become part of a notice of deficiencies to the provider agency and DOH waiver management staff are notified. A plan of corrective action must be submitted to the DOH survey staff. The survey team is in close communication with DOH waiver management staff who may request an investigation of a waiver provider be conducted by the CC.

Any reports of unauthorized restraint from any of these sources will prompt an immediate investigation of the agency. Along with investigation into a specific incident the CC may conduct face to face or phone surveys with other participants to determine the extent of the problem.

The CC conducts and analysis of all statewide SRIs and reports findings, analysis and trends with recommendation if appropriate to DOH waiver management staff quarterly.

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-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
- Yes. This Appendix applies** (complete the remaining items)

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Waiver participants living in a Residential Programs for Adults must be monitored regarding their ability to self-administer medications. Upon admission to the waiver program, every six (6) months and as necessary, the Service Coordinator gathers information regarding the participant's ability to self-administer medications. If problems are identified, the waiver participant is referred to an appropriate service provider for an assessment and/or training and assistance to ensure safe management of the participant's medication. An appropriate service provider may include providers of Medicaid State Plan services, other local, state or

federal program providers or a waiver service provider. In some instances informal supports may also be utilized.

Waiver provider staff are trained to be competent to provide second line monitoring with a special emphasis on participant's who take behavior modifying medications. At each contact with the participant, staff must observe whether any changes in normal functioning, personality or lifestyle have occurred. Examples may include: sleeping patterns, eating, level of alertness, mood, general appearance, medication routine, and so forth. All waiver provider staff who provide billable services included in the Service Plan are responsible for reporting any cognitive, physical and/or behavioral changes to their supervisor or to the Service Coordinator, which may require intervention.

Residents residing in Residential Programs for Adults through the NYS Office of Mental Health (OMH) must follow OMH regulations. Supervision is provided to each resident concerning self-administration and storage of their medications by OMH residence staff. In addition, the TBI Waiver Service Coordinator will monitor the management of waiver participant's medication(s) upon admission to the waiver program, every six (6) months using a multidisciplinary team approach (participant, family, waiver providers, OMH residence staff and Service Coordinator), and as needed. Each individual OMH residence is responsible to train their staff on signs and symptoms associated with side effects including any behavioral changes that occur. The OMH residence staff reports any problems to the outpatient provider(s) responsible for medication reviews, prescription renewals and changes in medication. The Service Coordinator is kept informed of any changes in a participant's medication regime by the OMH residence staff.

Medication monitoring to waiver participants who are residents of licensed Adult Care Facilities (ACF), for example Adult Homes, must follow specific DOH regulations regarding medication management and medication assistance. Each resident capable of self-administration of medication shall be permitted to retain and self-administer medication provided that the resident's physician attests, in writing, that the resident is capable of self-administration; and the resident keeps the ACF informed of all medications being taken, including name, route, dosage, frequency and any instructions including contraindications by the physician or pharmacy. Waiver participants living in an ACF who are in need of supervision and assistance with medication management will be provided their medications by the ACF staff. The ACF staff must provide the waiver participant with the proper dosage of medication, frequency, dosage and route. The ACF staff must observe and record that the waiver participant took his/her medication at the time the medication is provided to the waiver participant. This record must also include the time the medication is provided to the waiver participant, and if there are any contraindications of the medications. All allergies are listed in the medication assistance record. This record is reviewed daily by the ACF staff that assists in this area and at any time there is a medication refill. The Service Coordinator will also monitor the management of waiver participant's medication upon admission to the waiver program, every six (6) months, and as needed.

The scope of monitoring is designed to focus on medication usage patterns. ACFs were provided with a manual designed by DOH to use as a guide in training staff who provide care to residents. DOH provided the manual during the "Medication Assistance Train the Trainer" training program. New ACF staff must complete a 40-hour training program, which includes medication assistance training for the personal care staff who assist with medication.

The operator is responsible for having policies and procedures in place for each area of medication management. These include: the acquisition of new and refilled medications including identifying the process and identification of the individual or staff position responsible for performing the tasks; the storage of medications; the assistance with preparation; the recording of ordered medication; matching the medication with the resident for whom it is prescribed; the disposal of discontinued, unused or expired medication; and quality assurance of medication management priorities including the practices of residents who self-administer without assistance.

Each facility has a case manager who is responsible for monitoring, observing and evaluating resident needs which include medication management. If any resident shows any significant change in behavioral status or (or adverse reactions to medications), the case manager arranges for the resident to receive medical attention from his/her own physician. ACFs are monitored through the survey component of DOH survey process every 12-18 months, usually at 12-month intervals but this may depend upon the severity of violations sited. Those facilities with the highest compliance status usually do not warrant more frequent visits.

RAI: Residents residing in Residential Programs for Adults through the NYS Office of Mental Health (OMH) must follow OMH regulations. Supervision is provided to each resident concerning self-administration and storage of his/her medications by OMH residence staff. In addition, the TBI waiver Service Coordinator will monitor the management of waiver participant's medication(s) upon admission to the waiver program, every six (6) months using a multidisciplinary team approach (participant, family,

waiver providers, OMH residence staff and Service Coordinator), and as needed. Each individual OMH residence is responsible to train staff on signs and symptoms associated with side effects including any behavioral changes that occur. The OMH residence staff reports any problems to the outpatient provider(s) responsible for medication reviews, prescription renewals and changes in medication. The Service Coordinator is kept informed of any changes in a participant's medication regime by the OMH residence staff.

- 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.

ACFs are surveyed by survey component of DOH yearly or every 18 months. DOH has specific regulatory interpretations for medication assistance in ACFs. The ACF is cited for violation if it does not have policies and procedures for medication assistance in place or they are not in agreement with existing standards. DOH requires that the ACF facilities develop or revise policies and procedures related to medication assistance as part of their corrective action. Each ACF is also responsible to provide Quality Assurance for medication management.

OMH has specific regulations for medication management for their residences and are responsible for oversight of all medication issues. OMH surveys residences using a multi-tier system, which is based on provider deficiencies. Greater deficiencies are associated with higher tiers which translates to more frequent survey visits.

RRDS and Service Coordinator educate staff of the OMH licensed residences regarding the waiver's policies and procedures. Each time the Service Coordinator visits with the waiver participant, he/she will assure communication occurs with OMH residence staff about waiver participant's status. Communications will allow for discussion regarding any potentially harmful practices or findings brought to the attention of the Service Coordinator by OMH residence staff.

Home and Community Support Services as a waiver service may assist a waiver participant with self administration of medication following successful completion of an approved Personal Care Aid 40 hour training program which included training on assistance with self administration and compliance with other agency licensing rules. These providers must be employed by a licensed home care service agency (LHCSA) and are supervised by a registered profession nurse.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*
- Do not complete the rest of this section**

- ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix H: Quality Management 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 Management 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 Management 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 Management 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 Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy.

Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;
- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and
- The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Management 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 Management Strategy, including the specific tasks that the State plans to undertake during the period that 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 Management 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 identify the other long-term services that are addressed in the Quality Management Strategy.

Appendix H: Quality Management Strategy (2 of 2)

Attachment #1

The Quality Management Strategy for the waiver is:

The TBI Waiver Program embraces a participant-centered approach in the planning and delivery of waiver services, and has integrated this approach into different aspects of its Quality Management Program (QMP). The QMP encompasses quality assurance and quality improvement strategies to assure the system continuously measures program performance and identifies opportunities for improvement. The QMP consists of five levels based on the administrative structure of the TBI Waiver Program. Each level has responsibility to identify problems (Discovery), create solutions (Remediation), and be an active part in the change process of program policy (Improvement). The Department of Health (DOH) works together with providers, participants and their families to establish a system that ensures the quality of waiver services and participant satisfaction in an ongoing process.

The TBI Waiver Program's QMP system employs Discovery activities to collect data, analyze information and identify programmatic issues at different levels. Depending on the nature of the issues, Remediation strategy is employed at a provider, regional or statewide level to provide proper solution. The TBI Waiver Program recognizes QMP as a fluid and evolving process, and utilizes continuous Discovery strategies to monitor the effectiveness of the program policies. In the case that systemic issues on a programmatic level are identified, the TBI Waiver Management Staff would revise the existing policies to better reflect the current needs of the program. The Department of Health (DOH), the Clinical Consultant, Regional Resource Development Center (RRDC), Regional Resource Development Specialists (RRDS), Service Coordinators (SC) and other provider agencies form a collaborative network with waiver participants to work on his/her satisfaction and choice.

Level One consists of waiver participants and their natural supports. Waiver participants must have the necessary tools to self-direct their services to the best of their capabilities. Waiver participants work with their Service Coordinators and other waiver providers to develop Service Plans (SP) that reflect their personal goals and the strategies utilized to assure successful outcomes. The QMP continuously monitors the health and welfare of waiver participants through educating the participants about the TBI Waiver Program, holding Service Plan team meetings with waiver participants and providers once every six months, and providing access to the TBI Complaint Line to all waiver participants. Participants play an active role in the discovery process through communicating problems or issues to their waiver providers, Service Coordinators, and RRDSs. When problems are identified by waiver participants, the QMP incorporates the participants as a part of the remediation process to provide input and solution to assure successful outcomes. In addition, the TBI Complaint Line allows the program to have a mechanism for direct, unfiltered participant input that point out deficiencies on a systemic level.

Level Two of the QMP consists of the Service Coordinators and other waiver service providers. TBI Waiver service providers must employ self-monitoring strategies and examine the QMP within their own agencies in relation to the framework outlined in this application. The agencies' policies and procedures must meet the standards specified by the waiver program. The TBI Waiver Program provides the TBI Program Manual as a tool for service providers to

monitor the quality of their service delivery process. These tools include: policies regarding Service Plan (SP) development; Serious Incident Reporting Protocol, guidelines on team meetings; and DOH surveys and audits. In addition, the RRDS provides ongoing mandatory provider training and technical assistance when needed. In situations where problems are identified at the provider level, the waiver providers must evaluate whether the issue is specific to the staff involved, or if it is on a wider level involving the agency or the waiver program. If the provider's policy and procedures are the source of the problem, then the provider must change their policy and procedure to assure the health and welfare of waiver participants and comply with the standards of the TBI Waiver Program.

Level Three is the RRDC network. The RRDSs work with local districts to serve as the point of entry for the TBI waiver program by transitioning waiver participants from nursing homes, and to provide the waiver as an alternative to nursing home placements to the survivors of TBI. The RRDSs are responsible for both the programmatic and fiscal aspects of the waiver administration on a regional level. Their responsibilities include conducting outreach, education and training to the waiver providers, identifying community resources for waiver participants, networking with local community-based agencies, assuring proper level of care, maintaining and tracking an aggregate budget on a regional level to ensure budget neutrality, monitoring provider agencies, and approving Service Plans. The RRDSs compile and review the data collected from waiver providers and waiver participants in his/her region for quality assurance and submit findings to the Waiver Management Staff for further analysis.

Level Four is the Clinical Consultant, another key quality management component of the waiver program. The Clinical Consultant maintains regular contact with the RRDSs and DOH Waiver Management Staff on quality management issues and serves as a liaison among waiver providers, RRDCs and DOH Waiver Management Staff. Additionally, the Clinical Consultant provides technical assistance in clinical expertise to RRDSs on participants with complex needs, as well as on regulatory issues. The Clinical Consultant analyzes data obtained from RRDS reports, retrospective record reviews, and Serious Reportable Incidents to monitor regional trends. DOH may also ask the Clinical Consultant to conduct Serious Reportable Incidents cases that are programmatically sensitive. The Clinical Consultant works with the RRDSs and waiver providers to remedy any issues discovered, and make recommendations to DOH Waiver Management Staff for systemic improvements. As a part of the QMP, the Clinical Consultant reviews all Service Plans that are over an amount specified by the DOH Waiver Management Staff to assure that the health and welfare of the waiver participant are met in a cost-effective manner.

Level Five of the QMP is the DOH Waiver Management Staff, who has the ultimate authority for oversight and administration of the waiver program. The DOH Waiver Management Staff works collaboratively with other relevant DOH agencies such as Office of the Medicaid Inspector General (OMIG) and the DOH surveillance staff respectively on financial auditing and ensuring that the waiver providers meet the requirements outlined in the TBI Provider Manual and the Provider Agreement. Based on the framework of Discovery, Remediation and Recovery, the DOH Management Staff analyzes the aggregate data and reports collected from the RRDSs and the Clinical Consultant. These reports include Serious Reportable Incidents, Fair Hearings, site visits, financial audits, quarterly reports from RRDSs and the Clinical Consultant, quarterly meetings with RRDSs and the Clinical Consultant and provider surveys conducted by the survey component of the DOH.

The team analyzes the available data to implement remediation actions at the provider and/or regional levels. In situations where a wider systemic issue is identified, the team also works together to develop remediation or recovery strategies on a state or system-wide level. DOH Waiver Management Staff may initiate remediation actions such as additional provider training, restriction of the provider opportunity level (vendor hold) for providing additional services to participants, or termination of provider agreement. DOH Waiver Management Staff meets at least quarterly with the RRDSs and the Clinical Consultant to identify concerns and examine remedial actions. Once the remediation strategies are implemented, the staff continuously monitors the outcomes of these changes or improvements through ongoing Discovery measures to assure the standards of the waiver program are maintained through all levels of the QMP. DOH Waiver Management Staff works with the RRDSs and the Clinical Consultant to identify trends that may need to be responded to by a Remediation and /or Improvement activities to assure that the underlying philosophy and assurances of this waiver are maintained. DOH Waiver Management Staff monitors the Clinical Consultant and RRDCs by conducting on-site visits and quarterly reports to evaluate performance and to identify issues that require attention.

The Quality Management Program is a fluid and ongoing process. The TBI Waiver Program recognizes that the QMP strategies may change over time in response to the changing needs of the TBI Waiver Program and the New York State. The success of the QMP strategies are reviewed minimally at every quarterly RRDS and Clinical Consultant meeting, with the submission of RRDS and Clinical Consultant quarterly reports, at the discretion of DOH Waiver Management Staff, and annually. An annual summary and report is sent to CMS describing the ability of the waiver program to meet the assurances described in the application.

The following illustrates how assurances established by CMS will be met. This includes: monitoring provider performance through data collection and analysis (Discovery); providing guidance to providers that better assists them in following the policies and procedures of the waiver (Remediation); and developing strategies needed to assure improvements that support program standards. This is a continuous process that involves all levels to assure its

success. Overall improvements are made at the State level based on aggregation of the data and continuous dialog with all involved levels, facilitating changes in policies and standards on a provider, regional or statewide level. These Improvement activities are also monitored by all levels of the QMP to assure that expected results are actually achieved.

Quality Assurances

A. LEVEL OF CARE

A.1. -- WAIVER APPLICANTS FOR WHOM THERE IS REASONABLE INDICATION THAT SERVICES MAY BE NEEDED IN THE FUTURE ARE PROVIDED AN INDIVIDUAL LEVEL OF CARE EVALUATION

1. The RRDS is responsible for assuring individuals are informed about the waiver application process including the need for a LOC evaluation.
2. If the RRDS has concerns about an individual meeting the LOC criteria, a LOC evaluation will be completed by a qualified assessor, such as physicians or neuro-psychiatrists, prior to the development of the application packet by the SC.
3. As a part of the application packet, the SC assures that a current PRI and SCREEN is/has been completed to evaluate LOC.
4. The SC submits the application packet, including the PRI and SCREEN, to the RRDS who reviews 100% of all applications received to assure compliance with eligibility criteria, including LOC.
5. If the individual's LOC evaluation does not meet the program criteria, the RRDS will assure that the individual is referred to other community resources either by the RRDS or SC.
6. If the individual's LOC evaluation does not meet the program criteria, the RRDS will notify the participants their rights for Fair Hearing upon issuing a denial notice.
7. The RRDS will track all referrals
8. The Clinical Consultant will provide technical assistance in clinical expertise or related trainings to the RRDSs and providers when needed.
9. The Clinical Consultant reviews all service plans that are over the amount specified by the DOH Waiver Management Staff to ensure that the service plans protect the health and welfare of the high-need participants and are cost-effective.
10. The data gathered regarding this assurance will be included in the RRDS and the Clinical Consultant Quarterly Reports for review by DOH Waiver Management Staff. DOH Waiver Management Staff in consultation with the Clinical Consultant and RRDS will evaluate the need to make changes and/or improvements in policy/procedure.

A.2. -- THE LEVEL OF CARE OF ENROLLED PARTICIPANTS IS REEVALUATED AT LEAST ANNUALLY OR AS SPECIFIED IN THE APPROVED WAIVER

1. Waiver participants are reevaluated at least annually for LOC through completion of the PRI and SCREEN, which are included in the RSP and more frequently depending on the waiver participant's needs. The RRDS reviews 100% of all RSPs to assure ongoing compliance with waiver standards regarding LOC determinations.
2. The SC will create and maintain a tracking system to assure timely LOC reevaluations.
3. At a minimum of every six months, with the waiver participant present, the SC conducts a team meeting to review Service Plan (SP) for revision. If the team has concerns about the LOC, a new LOC evaluation will be completed.
4. During review of a RSP, the RRDS will inform the SC if an updated PRI and SCREEN is needed or if the PRI and SCREEN indicate an inappropriate LOC. The RRDS will maintain a system to track all LOC reevaluations to assure timeliness of submission.
5. If additional services are needed or if the participant's level of need decreases, addendums are added to the Service Plans.

6. The RRDS will track data regarding all LOC reevaluations to monitor that this assurance is being met.
7. The Clinical Consultant will monitor for regional trends and suggest any additional training to the RRDS regarding the LOC process and waiver eligibility.
8. The Clinical Consultant reviews all SPs whose cost are over the amount specified by the DOH Waiver Management Staff to ensure that the health and safety participants with complex needs are met.
9. The survey component of DOH conducts record reviews during surveys of service coordination agencies to assure LOC determinations were timely and the PRI/SCREEN are conducted according to DOH standards.
10. The data gathered regarding this assurance will be included in the RRDS and/or Clinical Consultant Quarterly Reports for review by DOH Waiver Management Staff. DOH Waiver Management Staff in consultation with the Clinical Consultant and RRDS will evaluate the need to make changes and/or improvements in policy/procedure.

A.3. -- THE PROCESS AND INSTRUMENTS DESCRIBED IN THE APPROVED WAIVER ARE APPLIED TO LOC DETERMINATIONS

1. The NYS PRI and SCREEN are designated tools for documenting LOC and can only be completed by individuals properly trained and certified by the NYS DOH. The completed PRI and SCREEN is signed by the assessor, attesting to the validity of the assessment. If necessary, DOH Waiver Management Staff has the ability to verify the credentials of the assessor completing the PRI and SCREEN.
2. The RRDS reviews 100% of all initial and subsequent PRI and SCREENS for timeliness and to be sure the instrument indicates the waiver participant does meet the LOC requirement.
3. Each RRDC will maintain a system to track the timeliness and appropriateness of all LOC evaluations/reevaluations as set in the TBI Program Manual.
4. PRI/SCREEN is conducted annually for all participants; bi-annually for all high-needs participants whose total cost of service plans exceed over an amount specified by the DOH Waiver Management Staff.
5. The data gathered regarding this assurance will be included in the RRDS and/or Clinical Consultant Quarterly Reports for review by DOH Waiver Management Staff. DOH Waiver Management Staff in consultation with the Clinical Consultant and RRDS will evaluate the need to make changes and/or improvements in policy/procedure.

A.4. -- THE STATE MONITORS LOC DECISIONS AND TAKES ACTION TO ADDRESS INAPPROPRIATE LEVEL OF CARE DETERMINATIONS

1. The RRDS reviews 100% of all initial and subsequent PRI and SCREENS to be sure the instruments indicate the waiver participant does meet the LOC requirement.
2. The RRDSs ensure that Service Plans are updated at least every six months, and that PRI/SCREEN is conducted at least annually.
3. Participants are notified their Fair Hearing rights when applying to the Waiver
4. Participants received the Complaint Line phone number when enrolled to the Waiver; participants have the right to file complaints; RRDSs investigate each complaint filed.
5. The RRDSs may request technical assistance from the Clinical Consultant when it is determined that a problem or trend regarding LOC evaluation and decision is noted.
6. Before being discontinued from the waiver program, the SC will make referrals for other services, if needed. The SC works closely with the RRDS regarding discharge plans.
7. When discontinuing participants from the waiver program, the RRRS notifies the participants their rights to Fair Hearing upon issuing the termination notice.
8. The RRDS notifies the Clinical Consultant and DOH Waiver Management Staff of any Fair Hearings initiated due to LOC denials.
9. The RRDS will track all LOC denials

10. The Clinical Consultant will analyze data received from RRDS for regional trends and will address issues with RRDSs accordingly.

11. The data gathered regarding this assurance will be included in the RRDS and/or Clinical Consultant Quarterly Reports for review by DOH Waiver Management Staff. DOH Waiver Management Staff in consultation with the Clinical Consultant and RRDS will evaluate the need to make changes and/or improvements in policy/procedure.

B. INDIVIDUAL SERVICE PLAN (ISP)

B.1. -- ISP ADDRESSES ALL PARTICIPANT'S ASSESSED NEEDS (INCLUDING HEALTH AND SAFETY RISK FACTORS) AND PERSONAL GOALS, EITHER BY THE PROVISION OF WAIVER SERVICES OR THROUGH OTHER MEANS

1. The RRDS meets every potential waiver participant prior to the development of the Initial SP. This provides the RRDC with information regarding the potential waiver participant's unique strengths and needs. This information is used when the RRDS reviews the Initial SP. The information acquired by the RRDS during this interview is documented on a standardized Intake form which is shared with the selected Service Coordinator and used to develop the Initial SP.
2. The SC works with the waiver participant to establish the Initial SP, Revised SP and any Service Plan Addenda. The SP includes a range of services needed by the waiver participant including waiver and non-waiver services. The SP combines all services needed to address the waiver participant's health and welfare, personal goals and preferences and cultural traditions.
3. The waiver participant and/or legal guardian signature on the SP signifies acceptance of the plan.
4. A Plan of Protective Oversight (PPO) is reviewed and completed with the waiver participant by the SC initially, at each RSP review, and with an Addendum, if changes to the PPO are indicated at this time (see Appendix D).
5. All Initial and Revised SPs are forwarded to the RRDS for final review and approval. The RRDS conducts a comprehensive review of 100% of all SPs to assure the waiver participant's goals and preferences are recognized and the plan meets his/her health and welfare needs.
6. If the RRDS feels that the SP does not reflect the waiver participant's needs and goals, support the participants' health and welfare, or is not in compliance with the TBI Waiver Program's policies, the SC is required to take immediate corrective action and resubmit the corrected SP is for approval.
7. If the total cost of SP exceeds the amount specified by the DOH Waiver Management Staff, RRDS forwards the plan to the Clinical Consultant for approval
8. Waiver providers will assess waiver participants' satisfaction through conducting mandatory annual survey; providers are also required to have their own grievance policy to investigate complaints. Both the satisfaction survey and grievance policy are surveyed by the DOH survey staff.
9. Any calls received by DOH Waiver Management Staff, either directly or through TBI Complaint Line, will be directed to the RRDS for investigation; the outcome may include changes to the SP. Depending on the nature of the complaint, the Clinical Consultant may also investigate the complaints upon the request of DOH.
10. The Clinical Consultant conducts Service Plan review on all plans whose cost exceed the amount specified by the DOH Waiver Management Staff to ensure that the plans address participants' health/welfare
11. Participants who receive Individual Living Skills Training automatically receive a functional assessment that evaluates participant needs upon initiation of the service or when there is a noted change in participants' functioning. Participants also receive functional assessment on an annual basis.
12. The Neurobehavioral Project conducts functional and behavioral assessments for participants whose needs require Individual Behavioral Plans and conducts quality reviews of behavior plans
13. The data gathered regarding this assurance will be included in the RRDS and/or Clinical Consultant Quarterly Reports for review by DOH Waiver Management Staff. DOH Waiver Management Staff in consultation with the Clinical Consultant and RRDS will evaluate the need to make changes and/or improvements in policy/procedure.

B.2. -- THE STATE MONITORS SERVICE PLAN DEVELOPMENT IN ACCORDANCE WITH ITS POLICIES AND PROCEDURES AND TAKES APPROPRIATE ACTION WHEN IT IDENTIFIES INADEQUACIES IN SERVICE PLAN DEVELOPMENT

1. The RRDS is responsible to review 100% of all SPs and Addenda to assure they are developed in accordance with waiver participant needs and goals, meet health and welfare, and reflect the policies and procedures of the waiver program. Any discrepancies in the SP are referred back to the SC by the RRDS for further assessment and/or modification before re-review by the RRDS for approval.
2. Each SP that is submitted to the RRDS for review and approval. Each SP must be signed by the waiver participant and/or legal guardian to assure that the waiver participant agrees with the SP.
3. The RRDS assures that all SPs whose cost exceeds the amount specified by the DOH Waiver Management Staff are reviewed by Clinical Consultant prior to final approval.
4. The RRDS will compare all Serious Reportable Incidents against the SP and PPO to understand if a change in the type or the amount of service is needed and works with the SC to assure that any immediate need for change in the SP are made at the waiver provider level.
5. The SC is responsible for assuring that a safe and effective SP is established with the waiver participant's involvement and support. Plans are formulated initially and revised at least every six months or with more frequent Addenda, as needed. The SC has a tracking system in place to guarantee the timeliness of SPs.
6. The SC is responsible for facilitating team meetings with the waiver participant to review the SP for revisions to ensure the waiver participants' preferences are included. Service Coordinators are required to hold team meetings at least once every six months, but team meetings can be held at a more frequent basis depending on the need of the participant.
7. The SC submits the SP to the RRDS for review to ensure the SP is appropriate and to avoid any lapse in service coverage.
8. The DOH survey staff conducts provider surveys in an ongoing basis. Providers must send in Plan of Corrective Action if found to be in non-compliance with policies and procedures.
9. DOH Waiver Management Staff may place penalties on waiver providers for late submission of RSPs and/or Individual Service Reports (ISR). Penalties may include the discontinuance of the waiver provider agreement or a vendor hold, which prevents the waiver provider from accepting new waiver participants until the RSP is submitted and approved by the RRDS. In addition, the waiver provider may have to submit a plan of correction if the submission of late SPs is an ongoing problem.
10. At any time, DOH Waiver Management Staff may request RRDS or the Clinical Consultant to conduct review and/or a survey by the DOH survey staff on any waiver provider where inadequacies in the SP development process are identified.
11. Neurobehavioral Project conducts behavioral and functional assessments and design behavioral plans for participants on an as needed basis. The Project conducts quality reviews of behavior plans.

B.3. -- SERVICE PLANS ARE UPDATED/REVISED AT LEAST ANNUALLY OR WHEN WARRANTED BY CHANGES IN THE WAIVER PARTICIPANTS' NEEDS

1. The SC will assure that team meetings are held at least once every six months with the waiver participant for the purpose to review SP for revisions and develop a new Revised SP.
2. A SP Addendum is used when there is need for minor adjustments in the SP that are necessary to assure the health and welfare of the participants. The Addendum is a short form that the RRDS can review and approve quickly. An Revised SP is used when there are major changes in the types and amounts of waiver services that are needed to assure health and welfare. In an emergency, the RRDS can contact DOH Waiver Management Staff for technical assistance and provide immediate approval for services.
3. All Revised SP and Addenda must be approved by the RRDS to assure waiver participants' needs, goals, and health and welfare are met.
4. Waiver participant may request a review of his/her SP at any time and the SC must comply with this request. If

needed, a team meeting will be held with all the appropriate persons in attendance.

5. In the event that the outcome of an investigation of a Serious Reportable Incident, a Recordable Incident or a complaint leads to Service Plan Addenda or revisions of the SP, the RRDS will ensure that changes are implemented in a timely manner by the waiver providers.

6. The SC and RRDS will track the submission of SPs and review all SPs according to policy and procedure.

7. In case of late Service Plans, RRDS will notify DOH Waiver Management Staff. DOH will place providers on vendor hold if corrective action does not take place in the specified timeframe.

8. The data gathered regarding this assurance will be included in the RRDS and/or Clinical Consultant Quarterly Reports for review by DOH Waiver Management Staff. DOH Waiver Management Staff in consultation with the Clinical Consultant and RRDS will evaluate the need to make changes and/or improvements in policy/procedure.

B.4. -- SERVICES ARE DELIVERED IN ACCORDANCE WITH THE SERVICE PLAN, INCLUDING THE TYPE, SCOPE, AMOUNT, DURATION, AND FREQUENCY SPECIFIED IN THE SERVICE PLAN.

1. The SC will maintain regular contact, as described in the SP, with the waiver participant to discuss the delivery of services as approved in his/her SP.

2. The Clinical Consultant conducts reviews on all Service Plans whose cost is over the amount specified by the DOH Waiver Management Staff to ensure cost-effectiveness and the health and welfare of participants with complex needs. Additionally, the Clinical Consultant randomly reviews other service plans at the request of TBI Waiver Program.

3. The DOH Waiver Management Staff evaluates a random retrospective review of documentation from SPs against data acquired through eMedNY to assure the type of service approved, and the frequency and duration have been appropriately delivered in accordance with the SP (refer to Appendix I).

4. During DOH surveys and audits of waiver providers by the survey component of DOH, documentation is compared to the SP for accuracy to assure appropriate service delivery according to the SP.

5. Discrepancies between SPs and actual service utilization may be discovered through a range of methods including a random retrospective review of SPs, a comparison of SPs to claims data acquired through eMedNY, DOH surveys and audits of waiver providers, DOH Complaint Line calls, regarding waiver participant experiences with provision of services or through SRI investigations. If problems are discovered, further investigation may be warranted. If it is found that services are not being delivered in accordance with the SP, DOH Waiver Management Staff will take appropriate action which may include a vendor hold or termination of the Provider Agreement.

6. Service Coordinator fills out Service Plan schedule/timeline for all services. This form is included in the Service Plan package. Participant can contact Service Coordinator at any time if the services are not carried out as planned. Addendums can be added to the Service Plans if service frequency needs to be increased.

B.5. -- PARTICIPANTS ARE AFFORDED CHOICE BETWEEN WAIVER SERVICES AND INSTITUTIONAL CARE

1. The RRDS is responsible for outreach and community education regarding the TBI Waiver Program.

2. The RRDS interviews all potential waiver participants and offers them informed choice between community-based services and institutional care. The RRDS tracks the number of potential waiver participants interviewed and the number of potential waiver participants who choose waiver services over institutionalization.

3. The RRDS documents that potential waiver participants are offered choice between the waiver program and institutionalization by having the potential waiver participant and/or legal guardian sign the Freedom of Choice form during the initial phase of the application process. The signed Freedom of Choice form is included in the Initial Service Plan packet. Participants also sign the Rights and Responsibilities document to indicate that they understand their rights as waiver participants during the Service Plan review process annually.

4. The Clinical Consultant conducts reviews on all SPs whose cost exceed the amount specified by the DOH Waiver Management Staff to ensure cost-effectiveness and the health and welfare of participants with complex needs. Additionally, the Clinical Consultant randomly reviews other service plans at the request of TBI Waiver Program.

5. The DOH Waiver Management Staff conducts annual visits to the RRDS.
6. Potential waiver participants may contact the Complaint Line to express concerns about Freedom of Choice. DOH Waiver Management Staff will monitor the Complaint Line and take appropriate action to assure that all potential waiver participants are offered the choice between waiver services and institutional care.
7. The data gathered regarding this assurance will be included in the RRDS and/or Clinical Consultant Quarterly Reports for review by DOH Waiver Management Staff. DOH Waiver Management Staff in consultation with the Clinical Consultant and RRDS will evaluate the need to make changes and/or improvements in policy/procedure.

B.6. -- PARTICIPANTS ARE AFFORDED CHOICE AMONG WAIVER SERVICES AND PROVIDERS

1. In the initial interview with the potential waiver participant, the RRDS explains the use of waiver services.
2. During the initial interview, the RRDS assures individuals are offered choice in selection of SC by providing a list of available SCs for selection. The potential waiver participant is encouraged to interview Service Coordinators prior to making a selection. Upon selection of a SC by the waiver participant, the RRDS assures the Service Coordination Selection form is completed and signed by the waiver participant and maintained in his/her record.
3. The waiver participant is informed during the initial interview with the RRDS and again by the SC that at any time he/she may request a change in waiver providers, including SCs and complete a "Change of Provider" form. The SC assures each waiver participant is given a list of available qualified waiver providers for selection which is attached to the Provider Selection form. Upon selection of waiver provider(s), the SC will assure the agency can accept the waiver participant. The SC assures that the Provider Selection form is completed signed by the waiver participant and maintained in his/her record.
4. The SC assures the waiver participant and/or legal guardian signs the SP indicating his/her acceptance of waiver providers and waiver services selected.
5. On an annual basis the SC and all other waiver providers assure that the waiver participant reviews and signs a Participant Rights and Responsibilities form which includes information regarding a waiver participant's right to choose between/among waiver services/providers. A copy is kept in the waiver participant's record and given to the waiver participant.
6. If the participants are not satisfied with the kind of services they receive, they have the right to request a change of Service Coordinator or other provider agencies at any point.
7. All waiver providers are responsible for conducting annual Participant Satisfaction Surveys containing questions about "choice". These surveys can be reviewed during DOH surveys and upon request by the RRDS, Clinical Consultant and DOH Waiver Management Staff.
8. The data gathered regarding this assurance will be included in the RRDS and/or Clinical Consultant Quarterly Reports for review by DOH Waiver Management Staff. DOH Waiver Management Staff in consultation with the Clinical Consultant and RRDS will evaluate the need to make changes and/or improvements in policy/procedure.

C. QUALIFIED PROVIDERS

C.1. -- THE STATE VERIFIES ON A PERIODIC BASIS THAT PROVIDERS MEET REQUIRED LICENSING AND/OR CERTIFICATION STANDARDS AND ADHERE TO OTHER STANDARDS PRIOR TO THEIR FURNISHING STANDARDS AND ON A CONTINUOUS BASIS; THE STATE MONITORS NON-LICENSED/NON-CERTIFIED PROVIDERS TO ASSURE ADHERENCE TO WAIVER REQUIREMENTS.

1. NYS will only enter into Provider Agreements with agencies and/or individuals that meet the requirements for qualified staff.
2. Prior to approval, the RRDS conducts interviews of potential waiver providers which include evaluation of employee resumes, ensuring employees meet the required qualifications.
3. Waiver providers are responsible for assuring their staff meets all qualification requirements set by the waiver program

4. Character and competency verification will be obtained through direct contact with other State agencies where applicable
5. Certain waiver providers are mandated to obtain Criminal History Record reports from the U.S. Attorney General's Office for all prospective direct care and supervisory staff prior to employment other than those persons licensed under Title 8 of the Education law or Article 28-D of the Public Health Law (See Appendix C-2-a).
6. DOH Waiver Management Staff will verify waiver provider qualifications including licensure or certification status if appropriate upon signed Provider Agreement. The waiver provider must report any subsequent change in status to DOH Waiver Management Staff and/or RRDS/ Clinical Consultant.
7. The survey component of DOH will survey all licensed and/or certified and non-licensed/non-certified waiver provider agencies within the first three-years of the onset of the waiver including a component on staff qualifications.
8. If a waiver provider is found not to have met licensure/certification requirements (including the mandatory statutes for Employee Criminal History Record checks) DOH Waiver Management Staff reserves the right to place a vendor hold against the waiver provider and/or terminate the Provider Agreement.
9. A number of processes allow RRDSs, Clinical Consultant and DOH Waiver Management Staff to develop a sense of competencies and provide a good understanding of waiver provider capabilities. These are: review of SPs, Serious Reportable Incident reports, TBI Complaint Line, annual waiver provider Incident Reports, training materials and staff interactions.
10. The RRDS will communicate specific concerns regarding waiver provider practices to DOH Waiver Management Staff, leading to a DOH survey, audit or other possible further action as warranted.
11. The survey component of DOH conducts surveys of waiver providers to assure they adhere to policies and procedures including Incident Reporting, Detailed Plans and Individual Service Reports, concerns/grievances and SPs.
12. During surveys of waiver providers, the survey component of DOH will also evaluate to assure waiver provider employees meets job qualifications.
13. The data gathered regarding this assurance will be included in the RRDS and/or Clinical Consultant Quarterly Reports for review by DOH Waiver Management Staff. DOH Waiver Management Staff in consultation with the Clinical Consultant and RRDS will evaluate the need to make changes and/or improvements in policy/procedure.

C.2. -- THE STATE IMPLEMENTS ITS POLICIES AND PROCEDURES FOR VERIFYING THAT TRAINING IS PROVIDED IN ACCORDANCE WITH STATE REQUIREMENTS AND THE APPROVED WAIVER.

1. In the Program Manual, DOH Waiver Management Staff sets forth areas of training and competencies required for all staff of each waiver provider.
2. Waiver providers are responsible for maintaining ongoing training for their staff to assure that waiver compliance standards are met.
3. The RRDS provides training that includes Basic Orientation Training, Participant Rights, and service specific training programs to all approved waiver providers. The RRDS will maintain a list of all those trained and include this information in quarterly reports.
4. The RRDS will conduct 8-10 provider meetings per year with waiver providers in their region.
5. Documentation of training includes training curriculum, qualifications and name of trainer, attendance records, date and place of training, goals, and evaluation tools by waiver providers.
6. During DOH surveys and audits of waiver providers, documentation is reviewed to assure compliance with training standards. If compliance is not met, a plan of correction will be required and, if warranted, may lead to termination of the Provider Agreement.
7. DOH Waiver Management Staff, Clinical Consultant or RRDS may examine training curriculum or training records at any time.
8. The data gathered regarding this assurance will be included in the RRDS and/or Clinical Consultant Quarterly

Reports for review by DOH Waiver Management Staff. DOH Waiver Management Staff in consultation with the Clinical Consultant and RRDS will evaluate the need to make changes and/or improvements in policy/procedure.

D. HEALTH AND WELFARE

D.1. -- THERE IS CONTINUOUS MONITORING OF THE HEALTH AND WELFARE OF WAIVER PARTICIPANTS AND REMEDIATION ACTIONS ARE INITIATED WHEN APPROPRIATE.

1. The SC serves as a liaison between waiver providers, assuring ongoing communication occurs regarding issues pertinent to the waiver participant's health and welfare.
2. All waiver participants will be provided with a Contact Sheet listing SC, waiver providers, RRDS, and DOH Waiver Management Staff during the application phase by the SC. This information will be updated and provided to the waiver participant if any entity should change. These contacts allow for easier accessibility for waiver participants to communicate concerns regarding health and welfare.
3. The SC will facilitate Team Meetings with the waiver participant present at least every 6 months to review and revise the SP.
4. The RRDS will approve waiver participant applications, including the SP and PPO only if they set forth a plan to meet the waiver participant's health and welfare needs.
5. The SC will conduct face-to-face visits with the waiver participant based on the SP or as requested by the waiver participant.
6. All waiver provider staff will be trained to observe and report changes in the waiver participant's behavioral, physical and cognitive functioning and the process to follow if concerns arise.
7. Waiver providers will conduct a random sample of satisfaction survey annually.
8. DOH Waiver Management Staff will monitor calls received from the DOH Complaint Line for trends.
9. All Serious Reportable Incident reports received will be investigated according to policy and procedure by the RRDS(see Section G-1). The Clinical Consultant tracks data of the investigations done by the RRDSs on the regional level as well as by appropriate providers and neurobehavioral project on a quarterly basis.
10. Waiver provider trends, including frequency of Serious Reportable Incidents, are all monitored by the RRDS and Clinical Consultant in their region. The remediation actions of the waiver provider are imperative to the decreased likelihood of repeated events.
11. Waiver providers submit annual reports to the RRDS who reports to the DOH Waiver Management Staff for further trend analysis of Serious Reportable Incidents.
12. The data gathered regarding this assurance will be included in the RRDS and/or Clinical Consultant Quarterly Reports for review by DOH Waiver Management Staff. DOH Waiver Management Staff in consultation with the Clinical Consultant and RRDS will evaluate the need to make changes and/or improvements in policy/procedure. DOH Waiver Management Staff manages system performance ongoing based on the outcome of trend analysis.
13. If warranted, DOH Waiver Management Staff may initiate additional remediation actions including restriction of a provider's opportunity level (vendor hold) for providing services to participants or termination of a provider agreement.
14. In the cases where participants' waiver services are terminated, the participants are notified their rights to Fair Hearings by the RRDS.

D.2. -- ON AN ONGOING BASIS, THE STATE IDENTIFIES, ADDRESSES AND SEEKS TO PREVENT INSTANCES OF ABUSE, NEGLECT, AND EXPLOITATION

1. DOH Waiver Management Staff provides each waiver provider with the policies and procedures for Serious Reportable Incidents including abuse, neglect and exploitation reporting, investigation and monitoring of outcomes

(refer to section G-1).

2. Waiver providers have a Serious Incident Review Committee responsible for investigating reports of Serious Reportable Incidents and Recordable incidents, assuring appropriate and immediate corrective or disciplinary action has been taken and preventive measures are in place. Waiver providers submit an annual report for review to RRDS. RRDS analyzes the data for trends and makes recommendations for changes/improvements on a provider and regional level. This data is compiled and sent to DOH Waiver Management Staff. A copy is provided to the RRDS.
3. The Clinical Consultant assists the RRDS with training and other activities needed to address concerns.
4. During surveys, the survey component of DOH will review a waiver provider's policies and procedures for managing complaints and grievances. In addition the Provider's complaint/grievance log is reviewed to assure appropriate documentation, investigation and resolution has occurred and within timeframes specified in the TBI provide manual. Results of provider surveys are provided to RRDS, Clinical Consultant and DOH Waiver Management Staff for review, discussion and developing and implementing plans for needed Remediation and /or Improvement. DOH Waiver Management Staff maintain survey results in a database for further regional and statewide trend analysis.
5. The Clinical Consultant collects data on serious reportable incidents from the RRDSs on a quarterly basis and conducts an analysis for DOH on the overall trend and recommendations.
6. To measure system performance and to identify active or potential instances of abuse, neglect and/or exploitation, the Clinical Consultant periodically conducts phone interviews with randomly selected participants. In the cases where potential issues at the provider level exist, the Clinical Consultant may also call the participants to do more in-depth investigations.
7. To meet this assurance, DOH Waiver Management Staff serves as a centralized collection site to receive all information compiled from the Complaint Line, Serious Reportable Incidents, Provider survey outcomes, and quarterly and annual reports. Information is analyzed for regional and statewide trends. Outcomes are reviewed with Clinical Consultant and RRDSs for needed remediation which may include additional training programs, changes and/or improvements in policy/procedure, participant request for change in provider, restriction of provider opportunity level (vendor hold) and termination of provider agreement.
8. The TBI Waiver Management Staff keeps track of the cases received by the TBI Complaint Line. The complaint line cases are investigated and resolved at a provider and regional level by the RRDSs; depending on the level of severity or the nature of the complaint, the Waiver Management Staff may be involved with the investigation. Depending on the nature of the complaint, DOH may request the Clinical Consultant to conduct the investigation.

E. ADMINISTRATIVE AUTHORITY

E.1. -- THE MEDICAID AGENCY RETAINS ULTIMATE AUTHORITY AND RESPONSIBILITY FOR THE OPERATION OF THE WAIVER BY EXERCISING OVERSIGHT OVER THE PERFORMANCE OF WAIVER FUNCTIONS BY OTHER STATE AND LOCAL/REGIONAL NON-STATE (IF APPROPRIATE) AND CONTRACTED ENTITIES.

1. DOH Waiver Management Staff maintains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by contracted entities. Other units within the DOH, such as the New York State Office of Medicaid Inspector General, the survey component unit will be called upon for specific support as needed.
2. DOH Waiver Management Staff manages and oversees the performance of the contractors (Clinical Consultant and RRDC) through annual random retrospective reviews of the SPs, complaint line calls, quarterly and annual reports, complaints/grievances, and annual on-site visits with the RRDC and the Clinical Consultant. At any time, DOH Waiver Management Staff may determine that a decision by the Clinical Consultant, RRDC or RRDS does not reflect established policy, and will take action to assure that the waiver's policies and procedures are followed.
3. DOH Waiver Management Staff has the final authority regarding discontinuance of a waiver participant from the waiver program and for termination of a Provider Agreement.
4. DOH Waiver Management Staff anticipates open discussion with waiver participants, Clinical Consultant, RRDS's, waiver providers, LDSS and other community based organizations that serve people with disabilities and seniors to

understand and evaluate the functioning of the contractor's staff.

5. DOH surveillance staff maintains a database to gather, evaluate and monitor data collected from reports and survey results including Plan of Correction information. All the relevant reports gathered throughout this process are sent to the TBI Waiver Management Staff for review.

6. DOH Waiver Management Staff chairs RRDS/ and Clinical Consultant, Quarterly Meetings to review policies, network, present new policies/procedures, discuss regional trends and address waiver issues.

7. Any data gathered regarding this assurance will be included in the RRDS and/or Clinical Consultant quarterly reports for review by DOH Waiver Management Staff. DOH Waiver Management Staff, in consultation with Clinical Consultant and RRDS will evaluate the need to make changes in policy/procedure.

F. FINANCIAL ACCOUNTABILITY

CLAIMS FOR FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF WAIVER SERVICES ARE BASED ON STATE PAYMENTS FOR WAIVER SERVICES THAT HAVE BEEN RENDERED TO WAIVER PARTICIPANTS, AUTHORIZED IN THE SERVICE PLAN, AND PROPERLY BILLED BY QUALIFIED WAIVER PROVIDERS IN ACCORDANCE TO THE APPROVED WAIVER.

1. The claims for federal financial participation for these waiver services are subject to the same policies and procedures that the DOH - Office of Health Insurance Programs (OHIP) through the eMedNY system uses to claim federal financial participation for all other Medicaid services.

2. Each waiver provider is assigned a separate waiver provider identification number in eMedNY to assure that only qualified waiver providers are billing for services provided. Each waiver service is assigned a unique rate code.

3. Upon approval of the waiver participant's Initial SP, a waiver participant Exception Code, which is unique to the TBI waiver, is placed in eMedNY to assure that claims are paid only for individuals who were enrolled in the waiver program on the date of service.

4. All Medicaid claims submitted to eMedNY are subject to a series of edits to ensure validation of data. These edits include: whether the waiver participant is Medicaid eligible; whether the individual was enrolled in the waiver program on the date of service; and whether the Service Providers are enrolled waiver providers in NYS.

5. DOH Waiver Management Staff will compare a sample of the SPs reviewed with the claims for each waiver participant in this review to verify that the waiver services that have been rendered to waiver participants are authorized in the SP. DOH Waiver Management Staff will run queries to review participant Service Plans against claims data from the eMedNY system. Suspected discrepancies will be referred to the Office of the Medicaid Inspector General (OMIG).

6. OMIG is responsible for the Department of Health's duties as the single state agency for the administration of the Medicaid program in New York State with respect to fraud, waste and abuse. The responsibilities of the OMIG include, among other responsibilities, the Medicaid audit function. OMIG conducts audits on random providers annually. The DOH Waiver Management Staff, Clinical Consultant, and/or the RRDS may also recommend waiver providers to be audited and reviewed.

Upon completion of each such audit, final audit reports will be written disclosing deficiencies pertaining to claiming, record keeping and provision of service. These final audit reports will be sent to the waiver provider with a copy provided to DOH Waiver Management Staff. Based upon the OMIG audits, waiver providers' overall performance and financial controls can be evaluated.

7. Based on surveys conducted of waiver providers by the DOH survey staff, a financial audit may be triggered if areas of concern are identified.

8. To ensure that providers of Environmental Modifications, Assistive Technology, Community Transitional Services and Moving Assistance are billing properly, they are required to submit projected cost estimates and actual costs to the Service Coordinator. Upon financial audit of these providers, claim amounts will be compared to the amount that was approved.

9. As with any Medicaid service, the costs of waiver services that are the responsibility of a third party must be paid by that third party. If a waiver participant has a third-party insurance coverage, he/she is required to inform the Local Department of Social Services of that coverage.

10. Waiver service billing is the same as all Medicaid billing. Claims will be subject to the same adjudication process, which involves prepayment edits for third party billing.
11. If a waiver participant has third party coverage in the system and a waiver provider tries to submit a bill to Medicaid prior to billing the third party, an edit will prevent the waiver provider from receiving payment.
12. If it was found that a claim was paid prior to the input of third party insurance information, the State will pursue retroactive recovery of funds from the potentially liable third party insurance.
13. The Explanation of Medical Benefits (EOMB) process is designed to inform waiver participants of services provided to them according to Medicaid records, and seek to verify that services billed by waiver providers were actually delivered.
14. eMedNY provides waiver participants with EOMBs and instructions to be used as a means of communicating any discrepancies as it relates to the services billed for by the waiver providers. The forms are returned directly to the State's EOMB unit.
15. EOMBs can be produced for all, or for a random sample of waiver participants who received services. They can also be produced for specific waiver participants, waiver participants who received services from a specified waiver provider, or waiver participants receiving services related to a specified procedure or formulary code. The population of waiver participants who receive EOMBs is dictated by a set of user specified criteria. The maximum number that will be produced for a month is limited to 5,000 EOMBs.
16. DOH Waiver Management Staff will compile data received from internal queries, audits of claim detail reports, retrospective record reviews, Clinical Consultant quarterly reports, OMIG audits, DOH surveys, and participant complaints (including EOMBs). Data will be analyzed for regional and statewide trends.
17. Remediation efforts may include additional provider audits by OMIG, DOH provider surveys, reviews by DOH Waiver Management Staff, restriction of provider opportunity level (vendor hold), and/or termination of provider agreement.

RAI: The DOH TBI Waiver Management Staff utilizes several mechanisms to monitor the performance of the waiver program.

The Statewide Clinical Consultant reviews all Service Plans over \$400 per day to ensure that these clinically complex Service Plans are clinically sound and fiscally justified. In addition, the Clinical Consultant conducts retrospective reviews on 10% of the Service Plans annually to ensure Service Coordination providers and the RRDSs operate in accordance with the waiver assurances illustrated in this section.

DOH Waiver Management Staff currently has a contract with the Brain Injury Association to operate the TBI Waiver Complaint Line. The Complaint Line offers a toll-free number for waiver participants as an easy-to-access channel to register grievances. These complaints provide the DOH Waiver Management Staff an effective tool to monitor problems on a provider, regional, and state-wide level. Many of these complaints also shed light on possible programmatic issues on the regional and statewide level.

Additionally, the DOH surveillance unit surveys 10% of all TBI waiver providers each year to ensure providers meet the programmatic requirements outlined in the Program Manual (please see Folder #1 for Program Manual).

The TBI Waiver Management Staff, the DOH Surveillance unit and DOH's TBI contractors (RRDCs, Clinical Consultant and the Neurobehavioral Project) form a highly interdependent network. To ensure that all the programmatic, clinical and financial issues are adequately addressed and followed-up, they meet on a quarterly basis to discuss these issues and solutions. Contractors are also required to submit quarterly reports to the DOH Waiver Management Staff. Upon satisfactory performance, DOH Waiver Management Staff approves vouchers for payment for these contractors on a quarterly basis.

A full copy of the NYS DOH 2006 TBI Waiver Assessment Report approved by CMS in June 2007 has been provided to the CMS regional office. As discussed with CMS staff, Book #1 of the NYS DOH 2006 TBI Waiver Quality Assessment Report, "Overview Section," responds to this question.

***H-1-c A full copy of the Quality Assurance Report approved by CMS has been provided to the CMS regional office. As discussed with CMS staff, Book #1 of the NYS DOH 2006 TBI Waiver Quality Assessment- "Overview Section " Summary Chart" Report responds to this question.

Regarding the question on Sample Size:

The Clinical Consultant conducts retrospective review on 10% of Service Plans annually. Areas reviewed include adherence to the philosophy of person center planning, justification of waiver services, qualification of providers, plans to continue increasing participant independence through decrease of staff or assistive technology and appropriate billing for services. All reviews are tracked individually by the Clinical Consultant and provided to DOH in a quarterly report. Trends are identified and analyzed. Concerns and suggestions for policy changes are made to DOH on the quarterly report. In addition to the retrospective review, all Service Plans over \$400 per day are reviewed on an ongoing basis. When critical concerns are identified, the Clinical Consultant contacts DOH Waiver Management Staff immediately. The comments and suggestions of the Clinical Consultant are returned to the RRDS for revision of the Plan.

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).

DOH is the State agency responsible for monitoring payments made under the NYS Medicaid Program. In addition, the New York State Office of Medicaid Inspector General (OMIG) conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the eMedNY provider manuals.

18 NYCRR 517.3(b)(2) states, "All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the OMIG or DOH for audit and review. . . ."

To ensure the integrity of provider claims for Medicaid payment of waiver services, the OMIG will conduct audits of waiver providers as part of the agency's fiscal audit plan. All waiver providers are subject to audits performed by the OMIG. The frequency of audit of waiver providers will be dictated by overall audit demands and audit resources available to the OMIG. These providers will be targeted via Data Warehouse (eMedNY) monitoring and provider profiling which will identify claiming patterns that appear suspicious or aberrant. The DOH Waiver Management Staff, the Statewide TBI Program Clinical Consultant and/or the Regional Resource Development Specialist may also recommend providers to be audited and reviewed.

As with any Medicaid service, the costs of waiver services that are the responsibility of a third party must be paid by that third party. If a waiver participant has a third-party insurance coverage, he/she is required to inform the Local Department of Social Services of that coverage. Waiver service billing is the same as all Medicaid billing. Claims will be subject to the same adjudication process, which involves prepayment edits for third party billing.

If a waiver participant has third party coverage in the system and a provider tries to submit a bill to Medicaid prior to billing the third party, an edit will prevent the provider from receiving payment. If it was found that a claim was paid prior to the input of third party insurance information, the State will pursue retroactive recovery of funds from the potentially liable third party insurance.

Under the provisions of the Single Audit Act as amended by the Single Audit Act Amendments of 1996, the New York State Division of Budget contracts with an independent entity, Toski et al, to conduct the independent audit of state agencies, including the Department of Health and its waiver programs.

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).

There are several methods employed to determine provider rates for the waiver services. While different methods are utilized, waiver payment rates are all sufficient to enlist enough qualified waiver providers.

With the exception of non-medical payments (such as Community Transitional Services, Assistive Technology, Environmental Modifications and Transportation), all rates are established by maintaining a state established fee-for-service schedule and may include regional adjustment factors.

The rates for Service Coordination, Community Integration Counseling, Home and Community Support Services, Independent Living Skills Training, Positive Behavioral Interventions and Supports, Substance Abuse Program, Respite Services and Structured Day Program are Statewide fee-for-service rates based on comparable rates for other waiver programs and services. The rates for Assistive Technology, Community Transitional Services and Environmental Modification Services are based on actual costs plus an administrative fee. Transportation costs reflect non-medical trips captured by the service coordinators for TBI waiver participants, i.e., all non-medical trips that are billed via a voucher process with the respective New York State Local Department of Social Services or through the New York State Department of Health's system for provider claims and reimbursement (eMedNY) for TBI waiver participants. The NYS Division of Budget and DOH are responsible for establishing a reimbursement rate for each waiver service.

[NOTE: The RRDCs are an administrative cost for DOH and are compensated as contractors. The costs for RRDCs are not part of the rate setting process.]

Rate information is made available to waiver participants in their Service Plans. Each Service Plan describes the frequency and duration of each service, the annual amount of units, the rate per unit and the total annual cost of each service.

RAI: NYS does not formerly solicit comments on the rate methodology determination from providers. However, in 2006 and 2007, DOH conducted regional forums around the State soliciting comments/concerns of waiver participants and providers and suggestions on ways to improve the provision of waiver services. At these forums the issue of rates was frequently raised. Advocacy organizations and provider agencies expressed concerns that without a rate increase it was becoming more difficult to recruit and retain qualified providers.

DOH was able to analyze these concerns to effect change in the area of rate determination. DOH was able to implement a 9% across the board increase for all waiver services statewide (reflecting 3% COLA each year for the past 3 years) and a 30% downstate differential increase in rates for New York City, Long Island and Lower Hudson for professional waiver services (Service Coordination, Community Integration Counseling, Positive Behavioral Intervention Services, and Independent Living Skills Training).

- 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:

The flow of billing goes from the waiver provider directly to the State's claims processing system, eMedNY. In the eMedNY system, the reimbursement for the services provided are tested against whether the waiver service was: provided to a Medicaid recipient who has been approved for this waiver, whether it has the right rate code and whether the waiver provider has been approved to provide the billed service.

The Medicaid provider is responsible for ensuring the accuracy of appropriate Medicaid data, such as the Medicaid provider ID, Medicaid recipient ID, that the service was provided to an approved waiver participant and the rate code for the services provided.

RAI: As discussed with CMS staff during a phone conference, the information contained in the TBI Waiver Quality Assessment Report responds to these questions. The Report was reviewed and approved by Nicole Gillette at CMS in the Fall of 2007. A complete copy of the report has been delivered to Stephanie Fuentes at the Albany DMCH Field Office as requested by CMS. 1) See NYS DOH 2006 TBI Waiver Quality Assessment Report, Book #1 Section H-1 through H-4 – Provider Claim Detail Reports. 2) See NYS DOH 2006 TBI Waiver Quality Assessment Report, Book #2- "Financial Accountability" Evidence of recoupment by State Attorney General's Office. 3) See

NYS DOH 2006 TBI Waiver Quality Assessment Report, Book #3 - This entire binder outlines the DOH billing process. See "Overview" section, Attachment 1 (Flowchart) and Attachment 2- TBI Audit Plan.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (*select one*):

- No. Public agencies do not certify expenditures for waiver services.**
- Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public 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 public 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 Non-State Public Agencies.**

Specify: (a) the non-State public 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:

When the payment claim is submitted to eMedNY there are a series of edits performed that ensure the validation of the data. Some of the edits include: whether the waiver participant is Medicaid eligible; whether the individual was enrolled in the waiver program; &, whether the Service Providers are enrolled waiver service providers in NYS. The edit tests to ensure that a participant is eligible for waiver services will also verify that the participant was eligible on the date the service was provided. In addition, all waiver claims paid through eMedNY will be subject to all the common payment integrity edit tests, as well as those specific to waiver transactions.

All Service Plans reflecting a total cost established by DOH are reviewed by the TBI Program Statewide Clinical Consultant for quality and cost effectiveness. This review includes the justification of services, compliance with Medicaid and waiver regulations, as well as quality of life issues for the participant. Each Plan is reviewed with the participant's optimal level of independence in mind. Suggestions are made, when appropriate, for decreasing dependency on staffing & program services such as: a cohesive & positive team approach to challenges, & the possible use of assistive technology to augment Service Plans to increase independence. DOH Waiver Mgmt Staff will manually run queries to review participant Service Plans & compare them with claims data from the eMedNY system. In addition, validation of services provided will occur through various means including provider audits &

the Participant Satisfaction Survey process.

In addition, the Explanation of Medical Benefits (EOMB) process is designed to verify with waiver participants that svcs billed by providers were actually delivered. eMedNY provides waiver participants with EOMBs & instructions to be used as a means of communicating any discrepancies as it relates to the svcs billed by the waiver providers. EOMBs can be produced for all, or for a random sample of participants who received svcs. They can also be produced for specific participants, participants who received svcs from a specified provider, or participants receiving svcs related to a specified procedure or formulary code. The population of participants who receive EOMBs is dictated by a set of user specified criteria. The maximum number that will be produced for a month is limited to 5,000 EOMBs for NYS Medicaid recipients.

To ensure that claims will meet the essential test that billed waiver services have actually been provided to waiver participants, the OMIG conducts waiver provider audits to verify that all Medicaid claims for reimbursement are supported with a record of the services provided. The record includes: Name of participant; Date of Service; Staff performing the activity and time and attendance records; The start and end time of each session; A description of the activities performed during the session; & The participant's service goal plans that are being worked on & the participant's progress toward attaining those goals.

Furthermore, as part of the claim submission process, providers must sign a Claim Certification Statement which includes certification that svcs were furnished and records pertaining to svcs will be kept for a minimum of 6 years.

Non-medical payments (such as Community Transitional Services, Assistive Technology purchases, E-Mods, Transportation -provided through the State Plan - etc.) will also be processed in eMedNY. These services do not fit into the traditional rate setting process. Each specific payment will be based on the tasks performed or the equipment or parts provided.

In addition, for E-Mods, Assistive Technology purchases & Community Transitional Services, the Service Coordinator will receive projected cost estimates and the actual costs to ensure that these costs are compatible. If there is a 10% or greater difference between the projected and actual costs, TBI Waiver will require an Addendum to the Service Plan to justify the increase. Upon financial audit of the provider, the OMIG will ensure that the claim amount is the same as the actual cost amount. In addition, as with any waiver service, all providers of Environmental Modifications, Assistive Technology, Community Transitional Services and Transportation (State Plan) are enrolled TBI waiver providers, thus subject to financial audits by the OMIG. All TBI waiver service providers are responsible for keeping records sufficient to substantiate any Medicaid claims. These providers are audited on the accuracy and validity of such records to ensure that claim amounts are accurate and valid.

Community Transitional Services is billed through a Service Coordination agency chosen by the waiver participant. The Service Coordination agency must keep receipts for services rendered as part of their record keeping requirements. Through a survey or audit, the survey component of DOH and/or the OMIG will examine the records of the Service Coordination agency to confirm that the receipts are present, and that the claim was accurate and valid based on the documentation of expenditures in the waiver participant's file.

RAI: Validation of svcs is conducted by DOH on several levels. 10% of all provider agencies are randomly surveyed each year by the DOH Survey Unit. This survey includes a review of svc plans & corresponding billing for svcs specified in the Service Plan. Any time an RRDS has concerns about the delivery & billing of svc, a claim detail report is requested & conducted by DOH. The svcs billed are compared w/the svcs approved in the participant's Svc Plan. Participants may report that svcs have not been received. These complaints initiate review by DOH Waiver Mgmt Staff of claim detail reports to compare svcs provided & billed. DOH Waiver Mgmt Staff randomly & retroactively review claim detail reports of billing for svcs.

- 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 §74.53.

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:

Transportation costs reflect non-medical trips captured by the service coordinators for TBI waiver participants; all non-medical trips that are billed via a voucher process with the respective New York State Local Department of Social Services or through the New York State Department of Health's system for provider claims and reimbursement (eMedNY) for TBI waiver participants. These costs for State plan and waiver services transportation are tracked by the service coordinators and reported to TBI management staff for inclusion in factor D.

RAI: Information regarding State Plan and waiver transportation costs are obtained from two primary sources. The majority of transportation services are provided by enrolled Medicaid transportation providers. All costs for these services are processed through the eMedNY system. TBI waiver management staff receive and review an annual report from eMedNY for these transportation costs.

A much smaller portion of transportation services are provided to waiver participants through a voucher system. The waiver participant's Service Coordinator is responsible for obtaining prior approval and tracking voucher transportation services.

The Service Coordinator obtains reports from these providers regarding the date, time and mileage provided for a specific waiver participant. A copy of the voucher is maintained by the Service Coordinator for his/her reports and the voucher is forwarded to the local Department of Social Services for payment to the provider.

● **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 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 and (b) the types of providers to which such payments are made. 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 Public Providers.** *Specify whether public providers receive payment for the provision of waiver services.*

- No. Public providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. Public providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

- e. Amount of Payment to Public Providers.**

Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- The amount paid to public providers is the same as the amount paid to private providers of the same service.
- The amount paid to public 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 public providers differs from the amount paid to private providers of the same service. When a public 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 do not receive and retain 100 percent of the amount claimed to CMS for waiver services.

Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):

- 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.

Any agency that qualifies as governmental such as, SONYMA and the Dormitory Authority.

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) (MCOs) 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.**

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 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 public agencies as CPEs, as indicated in Item I-2-c:

The General Fund (state tax revenue supported) state share for Medicaid is also appropriated in the NYS Office

of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Children and Family Services, Office of Alcoholism and Substance Abuse Services, and State Education Department budgets. Funds are transferred from these agencies, upon approval from the NYS Director of Budget, to the Department of Health using the certificate of approval process [funding control mechanism specified in the State Finance Law, or through journal transfers, to the Department of Health (DOH)].

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 public agencies as CPEs, as indicated in Item I-2-c:

Medicaid State share is also provided through appropriations in DOH for funds (net of any federal share) received from drug rebates, audit recoveries and refunds, and third party recoveries; assessments on nursing home and hospital gross revenue receipts; and Health Care Reform Act (HCRA) revenues. Appropriations in OMRDD for the Mental Hygiene Patient Income Account and in OMH for HCRA also fund the state share of Medicaid and are transferred to DOH.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. Local 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 non-State level sources of funds for the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Revenues.

Specify: (a) the local 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 public 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 non-State Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the 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 public 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) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *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:
 - Provider taxes or fees**
 - Provider donations**
 - Federal funds (other than FFP)**

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:

Rates for waiver services are calculated on a statewide basis, with consideration made for regional differences in market basket costs. Rates are the same for a service regardless of type of living arrangements of the waiver participant. Thus, the provision of a service in a waiver participant's home will be the same as when the same service is provided in an Adult Home in the same region. There is no consideration of the cost of room and board in developing the rates.

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 (2 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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: 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	48099.30	16499.00	64598.30	73490.00	5871.00	79361.00	14762.70
2	49472.76	16994.00	66466.76	75694.00	6047.00	81741.00	15274.24
3	50897.18	17504.00	68401.18	77965.00	6228.00	84193.00	15791.82
4	52409.63	18029.00	70438.63	80304.00	6415.00	86719.00	16280.37
5	53975.53	18570.00	72545.53	82713.00	6608.00	89321.00	16775.47

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 Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	2739		2739
Year 2	3039		3039
Year 3	3339		3339
Year 4 (renewal only)	3639		3639
Year 5 (renewal only)	3939		3939

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 based on the average of the most recent final 372 reports (03/04, 04/05, 05/06). Since no significant additional capacity nor any participant flow variation from past experience is expected, this average length of stay was applied to the recipients utilization projected for all the projected renewal years.

The average length of stay calculated per above is 318.4 days.

RAI: For DOH responses to Appendix J-1, Appendix J-2-a & b, and Appendix J-2-c-iv, please see the CMS 372 Lag report for 4/1/03-3/31/04 attached to the hard copy letter from Deborah Bachrach to Sue Kelly, dated 5/30/08.

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 was calculated using the 3 year average reported on the most recent final 372's for the # of users by service and average units per server. Average annual unit costs were projected separately for Upstate New York and NYC due to the rate differential. COLA rate increases of 3% for each year were calculated on applicable services.

- 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' was calculated using the 3 year average reported on the most recent final 372's in aggregate. Rate increases of 3% for each year were calculated based on the total cost from the year before. An adjustment was made to remove the estimated impact of Medicare Part D for the years (or partial years) included in the baseline average during which Medicare Part D was not yet effective. The Medicare Part D adjustment was made using the percentage of dual eligibles in the TBI waiver during the year.

- 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 was calculated based on the total institutional cost for individuals with Traumatic Brain Injury. Some TBI recipients in institutions were identified by a particular field on the assessment tool. Other TBI recipients were identified through a tracking data base specified by that purpose. The recipient ID's were used in the cost extract program for institutional populations. The baseline calculation was made using the 3

year average reported on the most current final 372's in aggregate. An adjustment was made to remove the estimated impact of Medicare Part D for the years (or partial years) included in the baseline average during which Medicare Part D was not yet effective. The Medicare Part D adjustment was made using the percentage of dual eligibles in the TBI waiver during the year. Rate increases of 3% for each year were calculated based on the total cost from the year before.

- 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' was calculated based on the total institutional cost for individuals with Traumatic Brain Injury. Some TBI recipients in institutions were identified by a particular field on the assessment tool. Other TBI recipients were identified through a tracking data base specified by that purpose. The recipient ID's were used in the cost extract program for institutional populations. The baseline calculation was made using the 3 year average reported on the most current final 372's in aggregate. An adjustment was made to remove the estimated impact of Medicare Part D for the years (or partial years) included in the baseline average during which Medicare Part D was not yet effective. The Medicare Part D adjustment was made using the percentage of dual eligibles in the TBI waiver during the year. Rate increases of 3% for each year were calculated based on the total cost from the year before.

RAI: For DOH responses to Appendix J-1, Appendix J-2-a & b, and Appendix J-2-c-iv, please see the CMS 372 Lag report for 4/1/03-3/31/04 attached to the hard copy letter from Deborah Bachrach to Sue Kelly, dated 5/30/08.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Community Integration Counseling
Assistive Technology Services
Structured Day Program Services
Home and Community Support Services
Substance Abuse Program Services
Community Transitional Services
Environmental Modifications Services
Transportation Services
Independent Living Skills and Training Services
Positive Behavioral Interventions and Support Services
Service Coordination
Respite Services

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
Community Integration Counseling Total:						5200070.29
Community Integration Counseling	hour	1681	39.69	77.94	5200070.29	
Assistive Technology Services Total:						341211.16
Assistive Technology Services	per unit cap	326	1.00	1046.66	341211.16	
Structured Day Program Services Total:						10353818.58
Structured Day Program Services	hour	1029	529.58	19.00	10353818.58	
Home and Community Support Services Total:						81732909.38
Home and Community Support Services	hour	1974	2078.55	19.92	81732909.38	
Substance Abuse Program Services Total:						38760.00
Substance Abuse Program Services	hour	20	57.00	34.00	38760.00	
Community Transitional Services Total:						30000.00
Community Transitional Services	per unit cap	10	1.00	3000.00	30000.00	
Environmental Modifications Services Total:						808137.76
Environmental Modifications Services	pre modification	122	1.00	6624.08	808137.76	
Transportation Services Total:						331400.58
Transportation Services	per trip	293	1.00	1131.06	331400.58	
Independent Living Skills and Training Services Total:						18379089.86
Independent Living Skills and Training Services	hour	2209	213.50	38.97	18379089.86	
Positive Behavioral Interventions and Support Services Total:						2933230.50
Positive Behavioral Interventions and Support Services	hour	750	66.90	58.46	2933230.50	
Service Coordination Total:						11404010.50
Service Coordination- Initial	one time	300	1.00	557.36	167208.00	
Service Coordination- Monthly	month	2690	9.80	426.25	11236802.50	
Respite Services Total:						191334.86
Respite Services	day	17	32.68	344.40	191334.86	
GRAND TOTAL:						131743973.47
Total Estimated Unduplicated Participants:						2739
Factor D (Divide total by number of participants):						48099.30
Average Length of Stay on the Waiver:						318

Appendix J: Cost Neutrality Demonstration

J-7: PAYMENT OF SERVICES (01/07)

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
Community Integration Counseling Total:						5921748.00
Community Integration Counseling	hour	1865	39.69	80.00	5921748.00	
Assistive Technology Services Total:						378890.92
Assistive Technology Services	per unit cap	362	1.00	1046.66	378890.92	
Structured Day Program Services Total:						11788932.72
Structured Day Program Services	hour	1141	529.58	19.51	11788932.72	
Home and Community Support Services Total:						93407542.74
Home and Community Support Services	hour	2190	2078.55	20.52	93407542.74	
Substance Abuse Program Services Total:						58140.00
Substance Abuse Program Services	hour	30	57.00	34.00	58140.00	
Community Transitional Services Total:						60000.00
Community Transitional Services	per unit cap	20	1.00	3000.00	60000.00	
Environmental Modifications Services Total:						894250.80
Environmental Modifications Services	per modification	135	1.00	6624.08	894250.80	
Transportation Services Total:						367594.50
Transportation Services	per trip	325	1.00	1131.06	367594.50	
Independent Living Skills and Training Services Total:						20936772.88
Independent Living Skills and Training Services	hour	2451	213.50	40.01	20936772.88	
Positive Behavioral Interventions and Support Services Total:						3340204.61
Positive Behavioral Interventions and Support Services	hour	832	66.90	60.01	3340204.61	
Service Coordination Total:						12973371.15
Service Coordination- Initial	one time	300	1.00	579.07	173721.00	
Service Coordination- Monthly	month	2985	9.80	437.55	12799650.15	
Respite Services Total:						220258.95

Respite Services	day	19	32.68	354.73	220258.95	
GRAND TOTAL:					150347707.27	
Total Estimated Unduplicated Participants:					3039	
Factor D (Divide total by number of participants):					49472.76	
Average Length of Stay on the Waiver:					318	

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
Community Integration Counseling Total:						6692230.12
Community Integration Counseling	hour	2050	39.69	82.25	6692230.12	
Assistive Technology Services Total:						415524.02
Assistive Technology Services	per unit cap	397	1.00	1046.66	415524.02	
Structured Day Program Services Total:						13315071.07
Structured Day Program Services	hour	1254	529.58	20.05	13315071.07	
Home and Community Support Services Total:						105670946.17
Home and Community Support Services	hour	2406	2078.55	21.13	105670946.17	
Substance Abuse Program Services Total:						71706.00
Substance Abuse Program Services	hour	37	57.00	34.00	71706.00	
Community Transitional Services Total:						90000.00
Community Transitional Services	per unit cap	30	1.00	3000.00	90000.00	
Environmental Modifications Services Total:						980363.84
Environmental Modifications Services	per modification	148	1.00	6624.08	980363.84	
Transportation Services Total:						403788.42
Transportation Services	per trip	357	1.00	1131.06	403788.42	
Independent Living Skills and Training Services Total:						23647919.72
Independent Living Skills and Training Services	hour	2693	213.50	41.13	23647919.72	
Positive Behavioral Interventions and						

Support Services Total:						3772133.75
Positive Behavioral Interventions and Support Services	hour	914	66.90	61.69	3772133.75	
Service Coordination Total:						14635250.84
Service Coordination-Initial	one time	300	1.00	602.15	180645.00	
Service Coordination-Monthly	month	3279	9.80	449.82	14454605.84	
Respite Services Total:						250752.99
Respite Services	day	21	32.68	365.38	250752.99	
GRAND TOTAL:						169945686.94
Total Estimated Unduplicated Participants:						3339
Factor D (Divide total by number of participants):						50897.18
Average Length of Stay on the Waiver:						318

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 (renewal only)

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Integration Counseling Total:						7506587.16
Community Integration Counseling	hour	2234	39.69	84.66	7506587.16	
Assistive Technology Services Total:						453203.78
Assistive Technology Services	per unit cap	433	1.00	1046.66	453203.78	
Structured Day Program Services Total:						14942036.15
Structured Day Program Services	hour	1367	529.58	20.64	14942036.15	
Home and Community Support Services Total:						118645587.84
Home and Community Support Services	hour	2622	2078.55	21.77	118645587.84	
Substance Abuse Program Services Total:						87210.00
Substance Abuse Program Services	hour	45	57.00	34.00	87210.00	
Community Transitional Services Total:						120000.00
Community Transitional Services	per unit cap	40	1.00	3000.00	120000.00	
Environmental Modifications Services Total:						1073100.96

Environmental Modifications Services	per modification	162	1.00	6624.08	1073100.96	
Transportation Services Total:						439982.34
Transportation Services	per trip	389	1.00	1131.06	439982.34	
Independent Living Skills and Training Services Total:						26531196.65
Independent Living Skills and Training Services	hour	2935	213.50	42.34	26531196.65	
Positive Behavioral Interventions and Support Services Total:						4231157.40
Positive Behavioral Interventions and Support Services	hour	996	66.90	63.50	4231157.40	
Service Coordination Total:						16405723.10
Service Coordination-Initial	one time	300	1.00	627.85	188355.00	
Service Coordination-Monthly	month	3574	9.80	463.02	16217368.10	
Respite Services Total:						282872.20
Respite Services	day	23	32.68	376.34	282872.20	
GRAND TOTAL:						190718657.58
Total Estimated Unduplicated Participants:						3639
Factor D (Divide total by number of participants):						52409.63
Average Length of Stay on the Waiver:						318

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 (renewal only)

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Integration Counseling Total:						8372459.44
Community Integration Counseling	hour	2418	39.69	87.24	8372459.44	
Assistive Technology Services Total:						490883.54
Assistive Technology Services	per unit cap	469	1.00	1046.66	490883.54	
Structured Day Program Services Total:						16659702.40
Structured Day Program Services	hour	1479	529.58	21.27	16659702.40	
Home and Community Support Services Total:						132300497.35
Home and Community						

Support Services	hour	2839	2078.55	22.42	132300497.35	
Substance Abuse Program Services Total:						96900.00
Substance Abuse Program Services	hour	50	57.00	34.00	96900.00	
Community Transitional Services Total:						150000.00
Community Transitional Services	per unit cap	50	1.00	3000.00	150000.00	
Environmental Modifications Services Total:						1159214.00
Environmental Modifications Services	per modification	175	1.00	6624.08	1159214.00	
Transportation Services Total:						476176.26
Transportation Services	per trip	421	1.00	1131.06	476176.26	
Independent Living Skills and Training Services Total:						29584455.88
Independent Living Skills and Training Services	hour	3176	213.50	43.63	29584455.88	
Positive Behavioral Interventions and Support Services Total:						4719415.01
Positive Behavioral Interventions and Support Services	hour	1078	66.90	65.44	4719415.01	
Service Coordination Total:						18283210.70
Service Coordination-Initial	one time	300	1.00	655.17	196551.00	
Service Coordination-Monthly	month	3868	9.80	477.14	18086659.70	
Respite Services Total:						316693.71
Respite Services	day	25	32.68	387.63	316693.71	
GRAND TOTAL:					212609608.29	
Total Estimated Unduplicated Participants:					3939	
Factor D (Divide total by number of participants):					53975.53	
Average Length of Stay on the Waiver:						318