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:
This application seeks to make the following modifications to the current waiver program:
• A new assessment tool utilized to establish nursing facility level of care.
The Uniform Assessment System-NY (UAS-NY) provides a comprehensive assessment of the individual's health status, preferences, care needs, functional status and cognitive functioning and determines if the applicant meets the criteria for nursing home level of care. The individual must be assessed to need nursing home level of care as a direct result of the traumatic brain injury. The assessment must be dated within 90 calendar days of the Notice of Decision (NOD) effective date and be completed by UAS-NY trained assessors and authorized by a registered nurse. Other professionals (e.g. social worker, case manager) may contribute to the assessment. The PRI/SCREEN will no longer be utilized to establish NFLOC for waiver services effective ninety (90) days of approval of the waiver application.

• The definition of traumatic brain injury utilized for waiver eligibility has been modified to reflect the language in the enabling legislation establishing the program. Chapter 196 of the Laws of 1994, Article 27-cc, establishes the definition of traumatic brain injury as an acquired injury to the brain caused by an external physical force resulting in total or partial disability or impairment and shall include but not be limited to damage to the central nervous system from anoxic/hypoxic episodes or damage to the central nervous system from allergic conditions, toxic substances and other acute medical/clinical incidents. Such terms shall include, but not be limited to, open and closed brain injuries that may result in mild, moderate, or severe impairments in one or more areas, including cognition, language, memory, attention, reasoning, abstract thinking, judgment, problem solving, sensory perceptual and motor abilities, psycho-social behavior, physical functions, information processing and speech. Such terms shall not include progressive dementias and other mentally impairing conditions, depression, and psychiatric disorders in which there is no known or obvious central nervous system damage, neurological, metabolic and other medical conditions of chronic, congenital or degenerative nature of brain injuries induced by birth trauma. All currently served waiver participants will remain eligible for waiver services until such time as a participant is determined to be no longer eligible. At which time, the participant will be given a Notice of Discontinuation from services, which includes, among other things, notification of the right to a Fair Hearing.

Enrollment projections are adjusted to reflect trends established in the last waiver period. Previous projections were over estimated. NYSDOH does not anticipate that the reduction in enrollment projections will restrict any applicant from receiving waiver services.

Service definitions are amended to enhance qualifications of providers, address staff supervision requirements and improve service delivery. Any currently approved provider who met 2008 waiver application qualifications on the date of approval of this application will be grandfathered in and the exception will terminate at the time the staff terminates employment with the provider.
For example:

• Any agency that employs two or more service coordinators must employ a Service Coordination (SC) supervisor.
• The supervisor must meet with each of the waiver participants served by the SC staff before approving the Revised Service Plan (RSP) and at least annually.
• SC Supervisors must meet with their staff monthly.
• SC Supervisors must review and sign all staff's service plans.
In other provider types:
• Assistive Technology is amended to expand the definition to include evaluation and assessments and training/technical assistance.
• Environmental Modifications is amended to include a new position "Home Evaluator" Home Evaluators must meet the following:
Certified Aging in Place Specialist and have two (2) years of experience in recommending and implementing assistive technology or durable medical equipment in the home health care domain;
Certified Environmental Access Consultant) in the field of environmental modification and have two (2) years of experience recommending and implementing assistive technology or durable medical equipment in the home health care domain;

OR
Licensed Occupational Therapist (licensed by NYS Education Department); OR
Licensed Physical Therapist (licensed by NYS Education Department).

A New position of "Driver Rehabilitation Specialist" was added to environmental/vehicle modifications. Driver Rehabilitation Specialists must meet the following qualifications:
Approved as a Driver Rehabilitation Specialist by ACCES-VR;
An individual with a Bachelor's degree and one of the following professional licenses/credentials:
Licensed Occupational Therapist (Licensed by the NYS Education Department), Licensed Physical Therapist (Licensed by the NYS Education Department),

In addition, the individual must be able to document three (3) years of experience providing driver rehabilitation services as defined by ACCES-VR.

OR
An individual with a Bachelor's degree certified as a Certified Driver Rehabilitation Specialist under the auspices of the Association of Driver Rehabilitation Specialists (ADED). In addition, the individual must be able to document three (3)years of experience providing driver rehabilitation services as defined by ACCES-VR.

• The service definition of Community Integration Counseling (CIC) is amended to reflect the following:
The participant must be present for any billable service. Collateral counseling is not permitted without the participant present.
The service does not duplicate services available through state plan: once counseling is no longer specific to community integration and becomes general counseling the service will terminate.
The assessment time is limited to five hours of direct service with the participant present.
Goals must be reasonable and attainable. Services do not extend beyond a two year period unless reviewed and approved by the RRDC.

• The service definition of Home and Community Support Services (HCSS) is amended to include the RN assessment and supervision visits.
Provides for three visits per year limited to 4 hours per visit.
Services are provided based on the total number of annual hours included in the service plan.

• Language in the service definition of Community Transition Services (CTS) is amended to reflect that housing security deposits must be credited through eMedNY.
Not for profit Housing agencies or Local Housing Authorities are added as providers.
Licensed pharmacies are added as providers.
Specific qualifications for employees were eliminated.

• The service definition for Independent Living Skills Training (ILST) is amended to reflect the following:
ILST cannot be provided in a structured day program setting.
The comprehensive functional assessment is completed annually by using the UAS-NY.
The participant must be present at the time of service delivery (including training of providers).
Justification to provide or continue services must be clearly stated in the plan and approved by the RRDS.
All agencies that employ two (2) or more ILSTs must provide supervision by an individual who fully meets the qualifications as an ILST provider. The supervisor shall meet with each waiver participant prior to approving the training plan developed by any

ILST staff person under their supervision, have supervisory meetings with their assigned staff on a monthly basis, and review and approve all training plans.
No additional hours are provided to complete initial and reassessments.

• The service definition for Positive Behavioral Supports and Interventions (PBIS) is amended to reflect the following:
The number of hours to complete behavioral assessments must be included in the service plan and is limited to ten (10) hours.
Information in the assessment must be consistent with the UAS.
Training hours cannot exceed ten (10) hours per service plan period and the participant must be present when the training occurs.
Any approved provider with two (2) or more Behavior Specialists must have a Program Director.
The Program Director is expected to meet any waiver participant prior to approving their behavior plan, have monthly supervisory meetings with the Behavior Specialists, review and sign-off on all participant behavior plans.
The hours required to write the plan are not billable.

The process for service plan review is amended establishing an annual revision of the service plan and a team meeting review every six months. Service plans are updated/revised at least annually and approved by the RRDC or when warranted by changes in the waiver participant's needs.

The definitions of Serious Reportable Incidents and reporting time frames are amended. The definitions are now consistent with 14 NYCRR Part 624; the regulations for the NYS Office of Persons with Developmental Disabilities (OPWDD).

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

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NY.0269
Waiver Number:NY.0269.R04.00
Draft ID: NY.007.04.00

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

E. Proposed Effective Date: *(mm/dd/yy)*
09/01/17
Approved Effective Date: 09/01/17

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

- (●) **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
  If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
- ( ) **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

- ( ) **Not applicable**
- (●) **Applicable**

Check the applicable authority or authorities:

- ☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under §1915(b) of the Act.**
  Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:
  Specify the §1915(b) authorities under which this program operates *(check each that applies):*
  - ☐ **§1915(b)(1) (mandated enrollment to managed care)**
  - ☐ **§1915(b)(2) (central broker)**
  - ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
  - ☐ **§1915(b)(4) (selective contracting/limit number of providers)**
- ☐ **A program operated under §1932(a) of the Act.**
  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
- ☐ **A program authorized under §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☑ **A program authorized under §1115 of the Act.**
  Specify the program:
  CMS approved an amendment to New York State's Medicaid section 1115 demonstration, Partnership Plan (11-W-00114/2) to provide home and community-based services through the TBI waiver to individuals with TBI who have a community spouse and to whom the spousal impoverishment eligibility and post-eligibility rules under section 1924 of the act are applied. The New York State Medicaid Director received authorization for the Home and Community-Based Services Expansion Program (HCBS Expansion Program) on April 8, 2010 to continue to serve such individuals now enrolled in the TBI waiver program as well as enroll new individuals using the same eligibility processes. The HCBS Expansion Program (1115 demonstration, Partnership Plan) provides home and community-based services identical to those provided under the TBI waiver program and is invisible to TBI waiver participants. All Medicaid claims submitted to eMedNY are subject to a series of edits to ensure validation of data, including waiver participant Medicaid eligibility; enrollment of the service recipient in the waiver on the date of service; and enrollment of the waiver service provider at the time of service. Duplicate billing does not occur.

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:
☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The TBI Waiver provides community-based alternatives to individuals with TBI between the ages of 18 and 64 years old at application and eligible for nursing home level of care. The TBI waiver allows waiver participants to avoid or transition from unwanted nursing home placement. The TBI waiver makes every effort to promote the right of waiver applicants/participants to choose participation in the waiver, identify needed services, and select service providers. Over the next five years this application is requesting to serve an additional 1517 individuals.

NYSDOH, Office of Health Insurance Programs (OHIP), Division of Long Term Care (DLTC),is responsible for the implementation and oversight of the TBI waiver. NYSDOH is designated as the single State agency responsible for the administration of the Medicaid program. The Deputy Commissioner of OHIP is the Director of the Medicaid Program and,in that capacity, is the signatory to the TBI waiver application. The Division Director of DLTC is responsible for policy and administration of long term care programs. This waiver is an important element of NYS' effort to restructure its long term care system.

NYSDOH, OHIP, DLTC, contracts with qualified not-for-profit organizations or agencies known as Regional Resource Development Centers (RRDCs) in regions across the state for the local administration of the waiver program. Each RRDC must demonstrate experience working with individuals with TBI, extensive knowledge of community based long term care services, an understanding of person centered planning and choice, and the ability to provide culturally competent services. The Regional Resource Development Specialists (RRDS) review all service plans before authorizing the applicant’s approval for waiver services. The service plan is reviewed annually to determine eligibility or whenever there has been a change with the participant’s health and welfare, providers, and/or Medicaid eligibility. Upon approval of the waiver applicant's Initial Service Plan (ISP), the RRDS notifies the Local Department of Social Services (LDSS)of the applicant's eligibility and a Notice of Decision (NOD)of Eligibility is issued by the RRDS.

Upon approval of this waiver application, a new electronic Uniform Assessment System (UAS) will be used to establish an individual's need for nursing home level of care and to evaluate an individual’s functional status, strengths, care needs and preferences. This information is used to develop that individual's service plan and to ensure the plan reflects needed care, within the appropriate setting and timeframes. The tool is designed to maximize efficiency and minimize duplication through automation of the assessment process.

An essential component of the TBI waiver is the waiver participant's right to choose a service provider, especially his/her Service Coordinator(SC). The SC is crucial to the waiver participants' success in the community, as they work with the waiver applicant/participant in the development, implementation, and evaluation of the service plan. The service plan is a document that contains vital information about the applicant/participant’s personal and medical history, lifestyle choices, informal supports, strengths, challenges, and service needs. The service plan is a reflection of the individual’s assessed needs, justifying the services requested in the plan and service preferences. It is revised annually and as needed to reflect the applicant/participant’s changing needs and focuses on maintaining his/her health and welfare in the community.

To assure services are provided in the most integrated and efficient manner, it is necessary for providers to attend regularly scheduled Team Meetings to discuss progress toward the participant’s goals, identify any impediments to achieving projected milestones and address any issues affecting the participant. Regularly scheduled Team Meetings with the participant and service providers are an essential part of assuring the participant’s health and welfare.

NYSDOH monitors service plan development in accordance with its policies and procedures through protocols clearly defined in the TBI Program Manual. This multi-level process includes the participant, SC, waiver service providers, RRDS, and NYSDOH. The TBI Program Manual outlines specific procedures with timelines for each level of service plan development, review and approval. Service plans are expected to evolve as the participant experiences life in the community, requests revisions, experiences significant life changes, or when new service options become available.

NYSDOH assures that services are delivered in accordance with the service plan, including type, scope, amount and frequency specified in the plan. Providers maintain documentation of participant outcomes. Such documentation may be in the form of standardized outcome measurements, or documentation of success in goal attainment from one service plan period to the next. Review of notes, Individual Service Reports (ISRs) and Detailed Plans are completed to determine if the participant's goals

were met. Each waiver provider is responsible for the delivery of services in accordance with the approved service plan.

The waiver participant is the primary decision-maker in the development of goals, and selection of supports and individual service providers. The SC is responsible for assuring that the service plan is implemented appropriately and supporting the participant to become an effective self-advocate and problem solver. Together they work to develop and implement the service plan, which reflects the participant's goals and choice of providers.

The TBI Program Manual further outlines program requirements and is available at:
http://www.health.ny.gov/health_care/medicaid/reference/tbi/docs/tbiprovidermanual2009.pdf

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been

made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally

liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
Chapter 196 of the Laws of 1994, Article 27-cc, established the NYS TBI Program within NYSDOH. This legislation charged the Department, "to develop a comprehensive statewide program with primary emphasis on community based services and to develop outreach services and to utilize existing organizations with demonstrated interest and expertise in serving persons with traumatic brain injuries and shall, within funds available, enter into contracts with such organizations."

The TBI enabling legislation also established the Traumatic Brain Injury Services Coordinating Council (TBISCC) (see Section 2744, Laws of New York, 1994, Chapter 196). The law charges the Council with recommending to the Department of Health long range objectives, goals and priorities. The Council also advises on the planning, coordination and development of needed services. The bylaws of the Council present its purpose as: "to continue to promote the health, safety and welfare of all the citizens of this state, the Department of Health shall develop, promote and encourage quality community-based health care, educational, residential, vocational, rehabilitation, family support and other essential services for persons with traumatic brain injury and their families. The Council shall be charged with recommending to the Department long range objectives, goals and priorities. It shall also provide advice on the planning, coordination and development of services needed to meet the needs of persons with traumatic brain injury and their families."

The Council is not directly involved in waiver services and its scope is broader than Medicaid service recipients. Its role is to recommend and advise NYSDOH.

NYSDOH maintains ongoing communication with its provider community through professional alliances and an open NYSDOH mailbox. Regional Resource Developmental Center staff meet regulary with the provider community, complete site visits to providers, conduct town meetings, participate in Team Meetings and visit participants and their families in their homes.

The RRDCs provide copies of Provider Meeting agendas and distributed information including sign-in sheets with their quarterly reports to NYSDOH. Feedback from meetings is discussed on monthly conference calls with NYSDOH and the RRDCs. NYSDOH administrative staff participant in ongoing conference calls with the provider community. Providers are advised that their issues are taken into consideration but do not necessarily dictate NYSDOH policy or the content and intent of the waiver application. Providers offer recommendations for revision to the Program Manual and waiver application on an ongoing basis. NYSDOH does not relinquish its authority to regulate the provision of Medicaid services.

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

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121)

and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name: Segal

First Name: Andrew

Title: Director Division of Long Term Care

Agency: NYS Department of Health

Address: One Commerce Plaza 99 Washington Avenue

Address 2: Room 1620

City: Albany

State: **New York**

Zip: 12260

Phone: (518) 408-6425 **Ext:** ☐ **TTY**

Fax: (518) 486-2564

E-mail: andrew.segal@health.ny.gov

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

Last Name: Hoffman

First Name: David

Title: Director Bureau of Community Integration and Alzheimer's Disease

Agency: NYS Department of Health

Address: One Commerce Plaza 99 Washington Avenue

Address 2:

Room 1620

City: Albany

State: **New York**

Zip: 12260

Phone: (518) 474-5271 **Ext:** ☐ **TTY**

Fax: (518) 474-7067

E-mail: david.hoffman@health.ny.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Jason A. Helgerson

State Medicaid Director or Designee

Submission Date: Aug 23, 2017

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

Last Name: Helgerson

First Name: Jason A.

Title: Deputy Commissioner/Medicaid Director

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

Address: One Commerce Plaza Room 1211

Address 2: 99 Washington Avenue

City: Albany

State: New York

Zip: 12210

Phone: (518) 474-3018 **Ext:** ☐ **TTY**

Fax: (518) 486-1346

E-mail: jason.helgerson@health.ny.gov

Attachments

Attachment #1: Transition Plan

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

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☑ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

In 2011, Governor Andrew Cuomo created the Medicaid Redesign Team (MRT). The goal of the MRT was to create significant reforms in New York's Medicaid program. The reforms take a "triple aim" approach of: 1) improving the quality of care by focusing on safety, effectiveness, patient-centeredness, timeliness, efficiency and equity; 2) improving health by addressing root causes of poor health, e.g., poor nutrition, physical inactivity, and substance use disorders; and 3) reducing per capita costs.

A critical component of the "triple aim" is Care Management for All. This initiative began in State Fiscal Year 2011-12 with the stated goal to have all Medicaid enrollees served in Managed Care. The Care Management for All approach will improve benefit coordination, quality of care and patient outcomes over the full range of health care, including mental health, substance abuse, developmental disability and physical health care services.

In keeping with this goal, the State is submitting a transition plan to eliminate the 1915c Home and Community Based Services (HCBS) Waiver for the Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) Programs and will transition participants into managed care programs operated by New York State (NYS). The timeline for this accomplishment has now moved on several occasions and the current target date is for the transition to begin January 1, 2019.

All information related to the Transition Planning Process and a copy of the draft transition plan is available at: https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/tbi-nhtd_waiver_trans_ingo.htm.

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

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

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

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver

complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

New York State (NYS) assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the New York State approved Statewide Transition Plan. The Corrective Action Plan (CAP) was approved June 27, 2017. The plan includes firewalls for implementation of COI Service Coordination effective upon approval of the application and full compliance effective January 1, 2019.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

NYSDOH is in the process of preparing to transition all service coordination functions into a structure that is compliant with Conflict of Interest (COI) standards. This transition will occur upon approval of the State's Corrective Action Plan (CAP) and until such time that TBI waiver services transition to managed care in January 2019. CMS approved the State's CAP to address compliance with conflict of interest (COI) regulations by January 2019 on August 10, 2017.

The Regional Resource Development Centers serve as the authorizing agent on behalf of NYSDOH for all services contained within the service plan. Services cannot be provided without the prior authorization of the RRDC, through the approval of a service plan. Effective via a 2016 contract amendment, RRDC contractors are restricted from direct service provision of waiver services. Additionally, the RRDC facilitates all eligibility and Level of Care determinations and determines waiver eligibility for all service applicants. All waiver service providers must be approved by NYSDOH. The RRDC must approve each service selection of providers requested by waiver participants prior to the provision of waiver services. The RRDCs provide a critical oversight function of waiver providers, participants and stakeholders in the region. The RRDCs will be responsible for facilitating the steps necessary to implement Conflict of Interest (COI) standards with providers and participants. This oversight will help to ensure that provider comply with COI guidance.

NYSDOH will facilitate the implementation of COI changes and will provide extensive guidance on an ongoing basis to the RRDCs, providers and waiver participants. Currently, the RRDC obtains and reviews all Freedom of Choice documents, provider selection forms and approves each service plan indicating service providers. Any discrepancies are discussed with the participant, provider and NYSDOH.

As providers move to compliance with COI compliance, first and foremost, waiver participants must be ensured continuity of services and continued access to care. A smooth transition to any new service provider is an existing program requirement. Current program protocols guarantee sufficient prior notification to ensure due process and sufficient protections for the individual. This includes and is not limited to: thirty day notice of change/termination of Service Coordination services, Notice of Decision (NOD) indicating a change, increase or reduction in services, complaint line protocols and participant satisfaction surveys.

NYSDOH will issue written guidance on the COI requirements and the subsequent programmatic changes that must occur. Providers will be afforded the opportunity to present how to effectively implement compliance with the new service criteria through routine Regional Provider meetings. Each provider will be required to submit an implementation plan to the RRDC delineating their proposed organizational structure and required firewalls that delineate the administrative and supervisory separation of care coordination services from direct HCBS service provision. All plans must be submitted and approved by the RRDC and NYSDOH.

NYSDOH will train all RRDCs in the compliance criteria for providers and oversight responsibilities of the RRDC. Additionally, due to proposed clarification associated with rate methodology, the RRDCs and providers will be provided instruction related to Certified Cost Reporting (CCR)and billing practices.

Any case directly impacted by the new COI criteria that requires re-assignment will be identified for transition. Any cases requiring transition to a new provider will be successfully transitioned by January 1, 2019.

Appendix A: Waiver Administration and Operation

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

   (●) **The waiver is operated by the State Medicaid agency.**

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

   (●) **The Medical Assistance Unit.**

   Specify the unit name:
   The Office of Health Insurance Programs, Division of Long Term Care
   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

   Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

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

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

NYSDOH, OHIP, Division of Long Term Care (DLTC), contracts with qualified not-for-profit organizations or agencies known as Regional Resource Development Centers (RRDCs) in regions established by NYSDOH across the state for the local administration of the waiver program. Each RRDC, must demonstrate experience in working with individuals with traumatic brain injury, extensive knowledge of community based long term care services, understanding of person centered planning and choice, and the ability to provide culturally competent services.

NYSDOH has the responsibility to assure informed choice of providers for all participants. The waiver participant is the primary decision-maker in the development of goals, and selection of supports and individual service providers. The RRDC has the principle role in providing participant choice between community-based services and institutional care. This includes information regarding the applicant's/participant's right to choose home and community based care and to select and/or change Service Coordination agencies and waiver service providers. All providers, including those already approved to provide Medicaid State Plan or services under another Medicaid waiver, are required to be enrolled specifically as a TBI waiver provider, and to meet all State licensure and credentialing requirements specific to the services for which they apply as established in the TBI Program Manual. The RRDC provides the potential participant with a list of approved Service Coordination providers and encourages him/her to interview potential Service Coordinators. The Service Coordinator is responsible for assuring that the service plan is implemented appropriately and supporting the participant to become an effective self-advocate and problem solver. Together they work to develop and implement the service plan, which reflects the participant's goals and choice of provider. In the event of coercion by providers, the provider will be subject to appropriate corrective actions. NYSDOH waiver staff utilize a number of audit functions to review and confirm these processes. These include file reviews, review of information contained on the statewide data base, desk audits of billing practices, RRDC quarterly reports and meetings, participant satisfaction surveys and complaint monitoring.

RRDCs perform waiver operational and administrative functions on behalf of the New York State Department of Health (NYSDOH). These include:

• Disseminating information about waiver services to community agencies, families and potential waiver participants by conducting informational meetings and community outreach events.
• Oversight and implementation of waiver participant enrollment: RRDC staff meet with each potential waiver participant to discuss waiver services; explain participants' rights and responsibilities; discuss participant choice and determining if the individual meets waiver eligibility criteria. Those individuals choosing to apply for waiver services receive a list of approved Service Coordination agencies that will assist the individual to select needed services and develop an Initial Service Plan (ISP).
• Monitoring waiver services and expenditures: RRDC staff review all service plans to ensure cost effectiveness and track and ensure timely submission of Level of Care (LOC) assessments.
• Reviewing participant service plans: RRDC staff review and approve all initial service plans (ISPs) to establish program eligibility. Revised service plans (RSPs) are reviewed and approved on an annual basis.
• Recruiting providers: RRDC staff assess the need for services in their regions and conduct outreach to potential providers. They encourage current providers to expand their scope of waiver services when appropriate. Potential providers are interviewed and referred to NYSDOH for enrollment.
• Conducting training and technical assistance: RRDC staff provide technical assistance to providers, participants, advocates, community services and other RRDCs.
• Receipt, oversight and investigation of participant complaint calls: The RRDC is responsible for investigation, review and resolution of complaints. By having the RRDC assess complaints at the local level, issues are addressed more quickly and the complainant is contacted directly by the RRDC. Often the RRDC is familiar with the issue(s) and can offer a more timely resolution to the problem. Complaints related to the RRDC are received directly by NYSDOH and the phone number is maintained on the waiver participant contact sheet posted in the participant's home. A copy of the complaint protocol and complaint line phone numbers is maintained on the NYSDOH website. Participants are informed of the outcome of the review of the complaint in writing. NYSDOH reviews complaint data on a quarterly basis and analyzes the information for trends and recurring issues. The Complaint protocol indicates: "if the subject of the complaint is the RRDC or another service within the New York State Department

of Health (NYSDOH), TBI waiver management staff will address the complaint or initiate review of the matter. For such complaints, please call the NYSDOH TBI Program at 518-474-5271." Any individual may contact NYSDOH to discuss concerns of any nature or if unsatisfied with the complaint resolution.

○ **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:

NYSDOH, OHIP, DLTC contracts with qualified not-for-profit entities in regions established by NYSDOH across the State for the local administration of the waiver program. The contractors must demonstrate to NYSDOH their experience providing services and conducting activities for the TBI target population through a Request for Application process. A copy of the Request for Applications (RFA) which becomes part of the contract document is located at the NYSDOH website: http://www.health.ny.gov/funding/rfa/inactive/0905010831/ and is located in the TBI waiver program area.

As contractually stipulated, the Regional Resource Development Center (RRDC) staff determine applicants'' non-financial eligibility for waiver participation, enroll applicants and service providers, organize local outreach and informational efforts, develop regional resources, train waiver service providers about waiver related processes and procedures, and otherwise assist administering, under NYSDOH's direction, the TBI waiver in each respective region. NYSDOH waiver staff provide direct oversight of the RRDCs and their operations. Each RRDC provides a quarterly report that describes the measurable outcomes identified in the contract workplan. Additionally, every month each RRDC provides a statistical report of intakes, discharges, enrollment and service plan reviews. This information is reviewed by NYSDOH waiver management staff on a daily and ongoing basis. Level of Care evaluations, Service Plan approvals and service authorizations are tracked on a statewide database and monitored by NYSDOH daily.

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 NYSDOH, OHIP, Division of Long Term Care (DLTC).

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:
The Regional Resource Development Centers (RRDCs) employ Regional Resource Development Specialists (RRDSs). NYSDOH requires that each RRDC employ one RRDS who is dedicated full time to the TBI program. This position is designated by NYSDOH as the Lead RRDS. NYSDOH also requires that each RRDC employ a Nurse Evaluator. Program Specific Clauses of the RRDC contract memorialize the minimum experience and qualifications for the Lead RRDS and Nurse Evaluator. The contract further defines that any candidate under consideration for these positions must be approved by NYSDOH prior to employment. If the contractor fails to fill the vacancy with a qualified professional, acceptable to NYSDOH, the contract may be terminated immediately. With reasonable notice and written justification, NYSDOH may require the contractor to remove from the contract any employee justified by NYSDOH as being incompetent, otherwise unacceptable, or whose employment on the contract is considered contrary to the best interests of the public or the State. The contract and the TBI Program Manual also establish the roles and responsibilities of the RRDC. The RRDC is responsible for the development, management, administration and monitoring of the TBI HCBS waiver on a regional level.

NYSDOH monitors the performance of the RRDCs on an ongoing basis. NYSDOH waiver management staff maintain daily contact with the RRDCs. Part of the administrative authority NYSDOH retains over RRDC contractors relates to reimbursement for contractual obligations monitored through review of contractor quarterly reports. RRDC performance is measured in relationship to the operational protocols established in the TBI Program Manual, the waiver application and the contract performance measures established in the RRDC contract workplan. Quarterly payments to RRDC contractors may be withheld pending the resolution of performance or compliance issues.

The Uniform Assessment System (UAS-NY) is a web based application maintained by NYSDOH that enables users to enter and maintain information in a single unique record. This information is reviewed by the RRDS. If there appears to be any question regarding the applicant's nursing home level of care, the selected Service Coordinator consults with the RRDS to resolve any identified issues. The RRDS may request that the RRDC Nurse Evaluator (NE) review the completed assessment and may conduct a face-to-face visit to verify the initial LOC finding or complete a new assessment.

As part of the service plan review, the RRDS: verifies that the UAS-NY assessment is complete; reviews medical verification to support the diagnosis of a TBI; confirms the age of the applicant at the time of application and the age s/he acquired their TBI and confirms that the applicant meets the LOC criteria for waiver participation.

Any concerns that suggest a LOC determination or eligibility determination is questionable are discussed with NYSDOH prior to issuance of the Notice of Decision (NOD). This is done through telephone calls with the RRDS staff at any time an issue arises. This process allows for discovery of any potential problems before issuing a Notice of Decision (NOD)-Denial of Waiver Program that relates to LOC determination.

A sample of participant records is reviewed during NYSDOH site visits to RRDC offices and/or through RRDC self-audits. The review is to assure that participant records include a completed LOC assessment and documentation of the LOC timeliness of the assessment within ninety (90) calendar days prior to the effective date of a NOD-Authorization). NYSDOH also has access to all UAS-NY assessment information via the web portal and generates reports from the database to establish the timeliness of reviews.

As part of its oversight functions, NYSDOH conducts random retrospective reviews, analyzing information and data available on UAS-NY assessment system, the TBI database and Electronic Medicaid System of New York (eMedNY).

NYSDOH provides technical assistance as needed to the RRDS or any applicant regarding the UAS-NY assessment process and/or other eligibility criteria to resolve discrepancies and ensure the consistent adherence to waiver requirements.

NYSDOH conducts quarterly meetings with RRDC contractors to review NYSDOH policies, discuss community resources, review performance measures and for training.

NYSDOH conducts monthly statewide RRDC conference calls and individual regional conference calls with the RRDSs. These calls are used to share methods to enhance program performance, evaluate training methods, discuss

participant and provider issues and review trends in research or services related to TBI.

NYSDOH reviews supplemental reports completed by the RRDSs. These reports include monthly statistical data reflecting intakes, referrals, plan reviews, discharges and enrollments. Quarterly complaint summaries and quarterly reports of Serious Reportable Incident data are completed by the RRDCs. These reports reflect aggregate data from approved providers in the region, who submit an individual provider report to the RRDC. In addition to providing significant information related to waiver operations, the reports help NYSDOH evaluate the RRDC's contractual performance and statewide waiver implementation trends.

RRDCs may also conduct town meetings with providers and participants as needed. These meetings are provided as an open forum for the RRDC to hear about issues and services. RRDCs conduct eight (8) to ten (10) provider meetings per year. These meetings are used to disperse information and offer technical assistance to providers.

Designated in the RRDC contract work plan is the requirement that each RRDC maintain a specific phone number to receive complaints. Service Coordinators are responsible to inform participants of the phone number and to review the process for filing a complaint with the participant. The complaint number is identified on the waiver participant's contact list posted in the participant's home. The complaint line is available to TBI waiver participants, their families and advocates for registering complaints and concerns. The complaint protocol and phone numbers are available on the NYSDOH website and can be found at: http://www.health.ny.gov/facilities/long_term_care/. Information can be found under the header entitled "Complaint Process for Medicaid Long Term Care Waivers".

RRDCs provide a quarterly report of complaints to NYSDOH using a statewide format. Aggregate data is reviewed by NYSDOH on a quarterly and annual basis and cross referenced to prior years' data to identify trends and issues in need of remedy. NYSDOH monitors this data for indicators of RRDC performance.

NYSDOH and the RRDCs maintain a database of participant and provider enrollment, service plan development and cost of services. This information is monitored by NYSDOH.

As established in their contracts, RRDCs are responsible for recruiting and maintaining TBI waiver providers. NYSDOH monitors the number, type and location of newly developed providers in each region by monitoring the database and reviewing each region's provider list on a quarterly basis. By contract, the RRDC is required to maintain sufficient provider capacity to ensure the delivery or waiver services in the region and offer sufficient participant choice in providers. NYSDOH reviews provider application packets to ensure that all appropriate transaction forms and letters of incorporation are complete, accurate and include correctly dated information prior to submission to OHIP's Bureau of Provider Enrollment.

Each RRDC completes an annual Participant Satisfaction Survey. NYSDOH issues the format and the RRDC is responsible for the distribution of the survey to waiver participants and receipt of responses. A statistically reliable sample size of active waiver participants with a ninety-five percent (95%) confidence interval and five percent (5%) margin of error as established by Raosoft, receives a survey with a stamped return address envelope. Each RRDC reviews and compiles their regional response data. NYSDOH compiles the statewide aggregate data collected from each RRDC and completes a comparative analysis to prior years' data.

Each RRDC conducts a retrospective review of RRDC participant files. This annual self-audit of records is a statistically reliable sample size of active waiver participants enrolled in the region with a ninety-five percent (95%) confidence interval and five percent (5%) margin of error as established by Raosoft. A standardized form for the audit is distributed by NYSDOH and utilized on a statewide basis. Missing historical information or insufficient information is noted as an identified problem in the record.

NYSDOH waiver staff:
maintain daily phone and email contacts with the RRDCs
review monthly and quarterly reports
provide annual site visits as needed
monitor the statewide database
oversee provider enrollment
monitor Serious Incident Reports, Investigations and Complaints
provide guidance and directives related to fair hearings

NYSDOH waiver management staff conduct RRDC annual site visits as needed to assess operational and administrative performance, to assure quality performance of these entities on an annual basis or as needed. During RRDC site visits or audit reviews, NYSDOH staff review a random sample of participant records to assure the presence of a completed and

signed Referral, Intake, Initial Applicant Interview and Acknowledgement, Freedom of Choice, Service Coordinator Selection, Provider Selection, and Participant Rights and Responsibilities forms.

During random retrospective record reviews, NYSDOH staff monitor for correct completion of the Initial Applicant Interview and Acknowledgement, Freedom of Choice, Service Coordinator Selection, Provider Selection, Participant Rights and Responsibilities forms in the record.

Responses to the annual Participant Satisfaction Surveys may be reviewed by NYSDOH when on site. The Participant Satisfaction Survey collects indicators related to:
Service Coordination: input into service plan development and team meetings
Participant Choice
Quality of Services
Community integration

Information retrieved via complaint lines is reviewed by NYSDOH to monitor complaints.

Record reviews of the RRDC self-audits are completed.

NYSDOH staff may audit or participate in provider meetings as available.

NYSDOH staff make every effort to visit each RRDC at least annually when sufficient staff and resources are available. If one RRDC presents the need for technical assistance or additional oversight, NYSDOH staff will work to visit the RRDC more frequently or will schedule specific conference calls to discuss issues.

NYSDOH staff review the RRDC contractors' internal tracking systems and discuss internal procedures. Each RRDC has established an internal tracking system for pertinent information such as intake, referrals, service plans and incidents to supplement existing NYSDOH data systems.

NYSDOH staff complete random reviews of the participant database to ensure that RRDC staff are entering the required information and LOC determinations are completed according to required time frames

NYSDOH monitors participant requests for fair hearings and the disposition of the case. RRDCs are monitored by NYSDOH to ensure that they have properly prepared and presented the case. This includes a review of the case summary, supporting documentation and the reason for the action. All RRDC related fair hearings are tracked by NYSDOH.

RRDC and NYSDOH waiver management staff work with NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff to facilitate on-site surveys for a sample of providers. RRDCs are provided with a copy of the deficiency report and notification of the accepted plan of correction.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☑	☐
Waiver enrollment managed against approved limits	☑	☑	☐
Waiver expenditures managed against approved levels	☑	☑	☐
Level of care evaluation	☑	☑	☑
Review of Participant service plans	☑	☑	☐

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Prior authorization of waiver services	☐	☑	☐
Utilization management	☑	☐	☐
Qualified provider enrollment	☑	☑	☐
Execution of Medicaid provider agreements	☑	☑	☐
Establishment of a statewide rate methodology	☑	☐	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐	☐
Quality assurance and quality improvement activities	☑	☑	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participant service plans timely submitted and approved in accordance with the TBI Program Manual (percentage = numerator: service plans approved every twelve months/ denominator: total number of approved service plans.)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Each RRDC completes an annual self-audit (retrospective review) of records. NYSDOH distributes a standardized form to be used by the RRDCs. NYSDOH completes site visits. NYSDOH database.

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

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a 5% error margin http://www.raosoft.com/samplesize.html
☑ **Other** Specify: RRDC	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of waiver applicants requesting fair hearings with a disposition rendered by the Court (percentage= numerator: total number of fair hearings in a calendar year resulting in an Administrative Law Court decision/ denominator: total number of fair hearings requested.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Daily notices from the Office of Temporary Disability Assistance

		Sampling Approach*(check each that applies):*

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of services that are delivered in accordance with the service plan including type, amount, scope, duration and frequency as specified in the approved service plan (percentage = numerator: total claims for sampled plans consistent with services projected in the service grid/ denominator: total number of sampled plans.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews on site, RRDC submission of service plans, eMedNY service utilization and payments

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a 5% error margin http://www.raosoft.com/samplesize.html
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of initial level of care (LOC) determination forms present in RRDC records sampled by NYSDOH staff where the initial LOC was completed within ninety days of the notice of decision (NOD) (percentage = numerator: number of initial LOC forms present in the RRDC record where the initial LOC was completed within ninety days of notice of decisions/ denominator: total records sampled)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
RRDC self-audit, NYSDOH database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with 5% error margin http://www.raosoft.com/samplesize.html
☑ **Other** Specify: RRDC	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Number and percent of participant service plans reviewed which indicate that the Revised Service Plan (RSP) was reviewed at the six month Team Meeting (percentage= numerator: team meeting minutes completed six months after the effective date of the service plans/ denominator: number of active service plans reviewed.)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
RRDC self-audit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a 5% error margin http://www.raosoft.com/samplesize.html
☑ **Other** Specify: RRDC	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
RRDC	
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of records identified by NYSDOH waiver staff during annual site visits consistent with the findings of the region's self-audit (percentage = numerator: the number of files reviewed by NYSDOH that indicated no deficiencies/ denominator: total number of files the RRDC audited that indicated no deficiencies.)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
RRDC self-audit reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a 5% error margin http://www.raosoft.com/samplesize.html
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. NYSDOH monitors the RRDC to ensure the contractor fulfills their contractual obligations and performance measures. This oversight includes, but is not limited to: technical assistance, monitoring of the RRDC administration of the program, identification of needed corrective action, and implementation and completion of those actions.

NYSDOH waiver management staff review the discharge/enrollment data with the RRDCs at quarterly meetings in conjunction with projected enrollment data in the waiver application. If data presented indicates the RRDSs need to expedite intakes, monitor service coordinator selection by applicants, and facilitate approval of initial service plans then a plan to remedy the problem is established.

Participant enrollment and discontinuation data is reviewed at each Quarterly RRDC meeting.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Pursuant to Prompt Payment provisions in the State Finance Law, state agencies must pay expenditure vouchers within thirty calendar days of receipt or the State is required to pay interest to the contractor for the period beyond the allowable 30 days. This "30-day clock", however, is stopped when the State identifies outstanding issues which need to be resolved. NYSDOH waiver management staff request that payment be held pending a plan of corrective action for any noted RRDC deficiencies.

NYSDOH may request a financial audit if program discrepancies cannot be resolved or additional concerns are raised.

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

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

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

Chapter 196 of the Laws of 1994, Article 27-cc, establishes the definition of traumatic brain injury as an acquired injury to the brain caused by an external physical force resulting in total or partial disability or impairment and shall include but not be limited to damage to the central nervous system from anoxic/hypoxic episodes or damage to the central

nervous system from allergic conditions, toxic substances and other acute medical/clinical incidents. Such terms shall include, but not be limited to, open and closed brain injuries that may result in mild, moderate, or severe impairments in one or more areas, including cognition, language, memory, attention, reasoning, abstract thinking, judgment, problem solving, sensory perceptual and motor abilities, psycho-social behavior, physical functions, information processing and speech. Such terms shall not include progressive dementias and other mentally impairing conditions, depression, and psychiatric disorders in which there is no known or obvious central nervous system damage, neurological, metabolic and other medical conditions of chronic, congenital or degenerative nature of brain injuries induced by birth trauma.

The applicant must be between the ages of 18 - 64 at the time of applying for services. Once enrolled in the program there is no maximum age limit to receive services.

If the age of onset of the brain injury is before age 22 and the individual meets the criteria for service provision within the Office for People with Developmental Disabilities, the Regional Resource Development Center will assess the individual to determine the most appropriate source of support and will make an eligibility determination. 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 unless a subsequent TBI is the primary cause for the individual requiring nursing home level of care.

The individual must be a Medicaid beneficiary with Medicaid coverage that supports community based long term care.

The individual must be assessed to need nursing home level of care (LOC) as established by the currently approved patient assessment instrument (UAS-NY) as a direct result of the traumatic brain injury.

The individual must choose to participate in the waiver and be able to identify a residence in which they will be residing when receiving waiver services. Residential settings of four or more unrelated individuals are excluded. Waiver participants at the time of the approval of the waiver application residing in a setting of four or more unrelated individuals will be grandfathered in until such time as the individual moves. The services and supports available through the waiver and other sources must be sufficient to maintain the individual's health and welfare in the community.

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)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c*.
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*.

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

- ( ) **A level higher than 100% of the institutional average.**

Specify the percentage:

Other

Specify:

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- [ ] **The participant is referred to another waiver that can accommodate the individual's needs.**
- [ ] **Additional services in excess of the individual cost limit may be authorized.**

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

- [ ] **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	3615
Year 2	3940
Year 3	4294
Year 4	4680
Year 5	5132

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

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

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

e. **Allocation of Waiver Capacity.**

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Each Regional Resource Development Center (RRDC) conducts community outreach activities. In addition, the Money Follows the Person Program, through its outreach program informs individuals and families of available community resources including the Traumatic Brain Injury waiver.

The most common referral sources are: self-referral or family member, hospital/nursing home discharge planners, out of state facilities, Licensed Home Care Service Agencies (LHCSA), social or day health care programs or a Local District Office for Social Services (LDSS).

The individual must provide medical documentation of Traumatic Brain Injury (TBI) from a hospital, rehabilitation facility, neuropsychologist, neurologist or other qualified professional. During the intake process the RRDS makes a preliminary assessment of the individual's eligibility.

Applicants must be determined eligible for Medicaid services that support community based long term care services and must meet nursing facility level of care (NFLOC) criteria due to their traumatic brain injury. The RRDS informs the applicant that a Level of Care (LOC) evaluation is required.

The Uniform Assessment System-NY (UAS-NY) provides a comprehensive assessment of the individual's health status, preferences, care needs, functional status and cognitive functioning and determines if the applicant meets the criteria for nursing home level of care. The individual must be assessed to need nursing home level of care as a direct result of the Traumatic Brain Injury. The assessment must be dated within 90 calendar days of the Notice of Decision (NOD) effective date and be completed by UAS-NY trained assessors and signed by a Registered Professional Nurse. Other professionals (e.g. social worker, case manager) may contribute to the assessment. In instances where the NFLOC score does not result in an eligibility determination, the assessment of the TBI population may be further enhanced by the addition of a subsequent clinical assessment or evaluation which focuses on cognitive and functional deficits, including the IADL challenges outlined above, mood disorders, and balance concerns. A second UAS-NY assessment may be completed by an approved UAS-NY assessor, who may also be the RRDC Nurse Evaluator. Should the second assessment fail to support NFLOC, the applicant may seek additional clinical evaluation via specialists with expertise in TBI disability and/or cognitive deficit examinations. The clinical evaluation must demonstrate evidence of neurocognitive, behavioral and/or functional deficits on physical examination or diagnostic testing and/or meet DSM-5 criteria for major neurocognitive disorder.

The individual must elect to participate in the TBI waiver program by signing a Freedom of Choice Form, and there must be available resources to assure the health and welfare of the individual within the community. An individual may only apply in one region at a time and cannot effectuate multiple referrals to regional offices.

The applicant chooses a Service Coordinator (SC) from a list of approved providers in the region to assist applicant in developing their initial service plan and establishing eligibility for waiver services. A service plan is developed by the SC in conjunction with the applicant. This plan of care describes the medical and other services (regardless of funding source) to be furnished, the frequency and duration of the service, and the type of provider who will furnish each service. The service plan and all supporting documentation is submitted to the RRDS for review and approval.

The applicant is determined eligible for waiver services as of the effective date of the Notice of Decision (NOD) issued by the RRDC. The NOD is issued upon approval of an Initial Service Plan (ISP) signed by the applicant, Service Coordinator/Service Coordination Supervisor, court appointed guardian (if applicable) and anyone designated by the applicant to participate in the development of the service plan along with the approved application packet. Necessary services must be in place and the services must be sufficient to reasonably ensure the welfare of the individual. The ISP must describe why the individual is at risk of nursing home placement without the services of the waiver and indicate how available supports and services identified in the plan support the health and welfare of the potential participant. The participant must actively participate in the waiver services identified in their service plan.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

- (●) **No**
- ( ) **Yes**

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

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

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- [ ] **A special income level equal to:**

Select one:

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

  Specify percentage: [ ]
- ○ **A dollar amount which is lower than 300%.**

  Specify dollar amount: [ ]

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

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

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

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

Select one:

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

  Specify percentage amount: [ ]

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

Specify:

[ ]

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's

allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

   i. **Minimum number of services.**

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

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

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

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

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

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

   Specify the entity:

   - (●) **Other**

   Specify:

   Designated professionals trained by New York State Department of Health (NYSDOH) to administer and interpret the Uniform Assessment System of NY (UAS-NY).

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:

Any qualified professional seeking to perform a LOC assessment using the UAS-NY must complete a mandatory training in order to access the assessment tool. This on-line training prepares assessors to use the application and the assessment instruments. It includes mandatory and recommended courses. In addition to providing a level of care score, the outcomes of the assessment identify home and community based programs that may appropriately serve the individual. Any approved TBI provider, RRDS and/or NYSDOH waiver management staff may perform and/or contribute to the assessment process. The UAS-NY requires a Registered Professional Nurse (licensed by the NYS Education Department) review and authorize the assessment. Other professionals (e.g. social worker, case manager) may

contribute to the assessment in accordance with program criteria.

A mandatory training module for assessors includes: Course 3500 Assessing Cognitive Function is designed to facilitate assessors questions and understanding of different ways that cognitive deficits may present itself with individuals with Traumatic Brain Injury.

The Service Coordinator assists the applicant in securing the LOC assessment, securing the necessary documentation to confirm the diagnosis of Traumatic Brain Injury, completing the medical and social history, confirming Medicaid eligibilty and acquiring any additional assessments or reports necessary to develop a comprehensive initial service plan. Supplemental materials, including assessment by the RRDS, physician notes, medical and psychological documentation, clinical observations and family interviews related to the participant's/applicant's condition, capabilities and social needs, are evaluated in addition to the UAS-NY to establish waiver eligibility.

The UAS-NY does not change or replace current New York State Department of Health regulatory requirements or New York State Education Department laws and regulations regarding conducting assessments.

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.

The Uniform Assessment System (UAS-NY) is used to initially and annually re-evaluate an individual's level of care and supports eligibility for waiver services. UAS-NY evaluates an individual's health condition, functional status, cognition, strengths, care needs and preferences. The UAS-NY application establishes a unique record for an individual. In one electronic record, health care providers have access to an individual's demographic information, residential and service delivery addresses, assessment information and assessment outcome information. The UAS-NY Community Assessment enables an assessor to review an individual's multiple domains of function, health, social support, service use, and other health related information. It guides the development of individualized long term care plans and ensures the individual receives the right care within the least restrictive setting. The content of the assessment has three domains: functional status, health conditions and cognition. Within those domains are sub-categories such as activities of daily living, neurological condition, memory recall ability and decision making skills. The assessment is a web-based software application that provides immediate access to assessment outcomes and results. It enables information to be shared among providers and captures all assessment and care planning information in one location. The tool promotes service identification from a strength-based perspective. The assessment provides a validated level of care and assessment. Data garnered can be used across service settings and customized as needed for specific settings. Assessment outcomes include: Level of Care (LOC), clinical assessment protocols, quality indicators, care planning assistance, aggregate reports, ad hoc reporting and resource utilization groups.

The HC-PRI instrument will be utilized for individuals who are transitioning out of a nursing home or hospital. The HC-PRI instrument is used to identify medical events, including current medical diagnosis, prognosis, capabilities of the individual to perform Activities of Daily Living (ADL), and behavioral difficulties. The UAS-NY assessment will be conducted on these individuals within 90 days of his/her enrollment into the waiver. NYS has done testing and compared the HC-PRI to the UAS-NY and the outcomes of the assessment tools were equivalent. The UAS-NY contained more information, which can assist in the service plan development.

The RRDS reviews one hundred per cent (100%) of all Initial Service Plans (ISPs) and Revised Service Plans (RSPs) and supporting documentation necessary to support waiver initial and continued eligibility including the UAS-NY assessment summary and outcome report. The RRDC's contract requires staffing to include the position of Nurse Evaluator, who is also a currently certified PRI/SCREEN assessor and UAS-NY certified to provide technical assistance and complete LOC determinations as needed.

Any concerns that suggest a LOC determination or eligibility determination is questionable are discussed with the NYSDOH staff prior to issuance of the NOD. This is done through telephone calls with the RRDS staff at any time an issue arises. This process allows for discovery of any potential problems before issuing a Notice of Decision (NOD) -Denial of Waiver Program that relates to LOC determination. In instances where the NFLOC score does not result in an eligibility determination, the assessment of the TBI population may be further enhanced by the addition of a subsequent clinical assessment or evaluation which focuses on cognitive and functional deficits, including the IADL challenges outlined above, mood disorders, and balance concerns. A second UAS-NY assessment may be completed by an approved UAS-NY assessor, who may also be the RRDC Nurse Evaluator. Should the second assessment fail to support NFLOC, the applicant may seek additional clinical evaluation via specialists with expertise in TBI disability and/or cognitive deficit examinations. The clinical evaluation must demonstrate evidence of neurocognitive, behavioral

and/or functional deficits on physical examination or diagnostic testing and/or meet DSM-5 criteria for major neurocognitive disorder.

NYSDOH staff complete random reviews of the participant database to ensure that RRDC staff are entering the required information and LOC determinations are completed according to required time frames in conjunction with the service plan.

Any issues related to LOC reassessment and eligibility are discussed during monthly RRDS phone conferences.

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

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

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

The UAS-NY replaces existing assessment instruments in certain settings. NYSDOH engaged internal and external statisticians to conduct field studies on the various tools (i.e., PRI) against the uniform LOC algorithm produced by the UAS-NY.

NYSDOH began using a phased approach to implement the UAS-NY with Managed Long Term Care plans beginning in October 2013. Field tests conducted by an external group were validated against data from the UAS-NY Beta test conducted during the summer of 2012. Statisticians found the UAS-NY algorithm generated an LOC score consistent with other instruments.

The UAS-NY Community Assessment is based on research, development, and validation conducted by interRAI, a not-for-profit research collaborative. The assessment instrument is more comprehensive than currently used assessment instruments and assesses multiple domains of function, health, social supports and service use.

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:

Upon renewal of this waiver application, the TBI waiver will utilize the UAS-NY tool to determine a potential waiver participant's initial level of care and their annual re-evaluations. The assessment is completed only by individuals trained in the use of UAS-NY. Only those individuals who have successfully completed the training are able to access the tool using web based or off line technology. Re-evaluations are conducted by the same qualified staff on an annual basis in conjunction with the annual service plan review.

Assessment outcomes including the level of care score are generated upon completion of the UAS-NY Community Assessment. The assessment outcomes present long term care options for the individual and identify persons who are nursing home eligible. Assessors are required to use their professional judgment to determine the appropriate program options for the individual.

The web based assessment is made available to the Service Coordinator. If there appears to be any question regarding the applicant's nursing home level of care, the selected Service Coordinator consults with the RRDS to resolve any identified issues. The RRDS may request that the RRDC Nurse Evaluator (NE) review the completed assessment and conduct a face-to-face visit to verify the initial NFLOC finding or complete a new assessment.

As part of the service plan review, the RRDS reviews the UAS-NY assessment to confirm that the applicant meets the NFLOC criteria for waiver participation; confirms Medicaid (MA) eligibility, reviews medical verification to support the diagnosis of a TBI; confirms residency and the age of the applicant.

The RRDC in conjunction with the Service Coordinator is responsible for assuring that the initial and annual NFLOC assessments are completed by qualified assessors and in a manner timely to waiver participation. The RRDC and Service Coordinator are responsible to gather the appropriate information to confirm that the waiver participant continues to require a level of care to participate in the waiver. RRDC and NYSDOH staff are able to access the UAS-NY through the Health Commerce System. Staff have the option to review the electronic records available in the UAS-NY or to review reports printed by the provider.

Initial evaluations are completed within ninety (90) days of the Notice of Decision authorizing eligibility for waiver services. Enrolled waiver participants are reevaluated, at least annually in conjunction with the annual service plan or at any time the participant experiences a significant change of condition.

The Nurse Evaluator within the RRDC may conduct their own UAS-NY for comparative purposes. They may also conduct additional assessments and complete a historical review of the individual's record. All of this information is reviewed in conjunction with the service plan.

Should the findings of the UAS-NY indicate an adverse action regarding waiver eligibility, the applicant/participant will be provided a Notice of Decision (Denial/Discontinuation) which advises the individual of their right to conference/fair hearing.

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):*

NYSDOH employs a number of procedures to ensure timely re-evaluations of NFLOC.

The LOC assessment is completed within ninety (90) days of the effective date of the Notice of Decision and annually thereafter. This information is maintained by the RRDC in a NYSDOH approved database. The RRDS is able to generate reports of all upcoming and past due re-evaluations. NYSDOH waiver staff also monitor the timely review of service plans and LOC assessments.

The Revised Service Plan (RSP) is completed on an annual basis and must contain a review and evaluation of the participant's progress and services while on the waiver. It addresses how waiver services continue to prevent nursing home placement and indicates whether these services should continue unchanged, be modified or discontinued. Service plan goals are consistent with service needs identified by the UAS-NY assessment.

The Service Coordinator is responsible to assure the waiver participant's UAS-NY assessment remains current each year in order to confirm and document that the participant continues to meet the waiver's level of care eligibility requirement.

The Service Coordinator (SC) must assure that the RSP and annual LOC re-evaluation is completed on a timely basis and submitted to the RRDC for review. The SC is also responsible for tracking dates when the annual LOC reevaluation and revised service plan (RSP) is due. The RRDC monitors the process monthly.

Late submission of a Service Plan and LOC assessment can result in the interruption of services to a participant and penalties to the provider agency.

When an RSP packet is not submitted to the RRDS by the Service coordinator at least sixty (60) calendar days prior to the end date of the current Service Plan, a Late Letter is sent to the Service Coordination agency supervisor by the RRDC. It informs the Service Coordination agency supervisor that communication with the RRDS is necessary and a plan to submit the RSP packet within seven (7) calendar days is expected.

The RRDS reviews one hundred percent (100%) of all LOC assessments for assurance that the participant has been reassessed in a timely manner and continues to meet the required nursing home LOC criteria. This information is entered into the TBI Program database. If the RRDS does not receive the assessment(s) in a timely manner, s/he will also notify the SC.

The UAS-NY includes a number of available reporting mechanisms regarding individuals assessed, aggregate or agency-wide reports, and ad hoc or customized reporting features. These reports are also used to monitor the timely completion of re-evaluations.

All LOC determinations reviewed by the RRDS are documented on the RRDS Revised Service Plan Review form.

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

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

The Service Coordinator is the primary person to arrange for the annual LOC reassessment by a certified assessor. Each Service Coordination agency and RRDC is responsible to maintain a system for tracking the annual LOC assessment due date.

The Service Coordinator and the RRDS are both responsible for the safe retention of all records for at least six (6) years following termination of waiver service to a participant.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
Number and percent of participant's initial LOC determinations (forms/instruments) that were correctly completed and authorized within ninety days of the Notice of Decision of eligibility (percentage = numerator: number of initial LOC determinations completed within ninety days of eligibility/ denominator: total number of initial LOC determinations completed for eligibility)

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:
NYSDOH review a sample of records that include files from the RRDC self-audit. The RRDC reviews 100% of all initial determinations at the time of application.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a 5% error margin http://www.raosoft.com/samplesize.html
☑ **Other** Specify: RRDC	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of enrolled waiver participants with a LOC re-evaluation completed within twelve months of the prior assessment (percentage = numerator: number of timely completed LOC re-evaluations/ denominator: total number of completed and overdue re-evaluations)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
100% of LOC assessements are reviewed by the RRDC at the time of the service plan review and authorization of services.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a 5% error margin http://www.raosoft.com/samplesize.html
☑ **Other** Specify: RRDC	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
One hundred percent (100%) of the enrolled waiver participants' initial, and annual (or both) level of care determinations are completed utilizing the required assessment tools (UAS-NY) as required by NYSDOH

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Only individuals identified by the RRDC or the assessing entities will be assigned UAS roles. The UAS-NY is the only NFLOC assessment accepted by the RRDC.

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

☑ **Other** Specify: RRDC	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
One hundred percent (100%) of waiver participants' initial, annual (or both) level of care (UAS-NY) determinations are completed by a trained assessor

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
Only individuals identified by the RRDC or the assessing entities will be assigned UAS roles. These designated individuals must complete the online UAS training prior to accessing the system.

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

		☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: RRDC	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. Regional Resource Development Specialists complete site visits to waiver service providers to discuss issues and to complete a random sample review of participant files. Any issues discovered by the RRDS are presented to NYSDOH waiver management staff and may prompt additional review by the Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff.

The Service Coordinator and the RRDS are both responsible for the safe retention of all records for at least six (6) years following termination of services to a participant. The records are maintained in their agency ensuring that they are readily retrievable if requested by CMS or NYSDOH.

Each Regional Resource Development Center (RRDC) completes an annual self-audit (retrospective review) of records. The number of files reviewed is a statistically reliable sample with a 95% confidence interval. All data

is sent to waiver management staff who complete a statewide data aggregation and analysis.

In addition, waiver management staff complete an audit of the statewide database to review Notice of Decision dates in relationship to assessment completion dates.

During on-site surveys of Service Coordination agencies, NYSDOH OPCHSM surveillance staff conduct random participant record reviews to assure compliance with the appropriate NFLOC criteria.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When the Service Coordinator is facing unforeseen circumstances that may prevent the submission of the LOC assessment and service plan within the required timeframe, the Service Coordinator immediately contacts the RRDS for technical assistance. A plan is established to prevent disruption of services to the participant, potential penalties to the Service Coordination agency, and billing concerns for all wavier service providers.

A Late Letter is sent to the Service Coordination agency supervisor by the RRDC any time a LOC assessment and servic plan packet is not submitted to the RRDS within the required timeframe.
Repeated submission of late, incomplete and/or unacceptable service plan packets and/or LOC assessments results in the initiation of corrective action. Failure to comply may lead to the initiation of a Vendor Hold process. Vendor Hold restricts the Service Coordination agency from accepting any new HCBS/TBI referrals.

NYSDOH waiver management staff retrain RRDC staff at quarterly RRDC meetings to ensure that services do not continue without a timely and valid LOC determination.

NYSDOH waiver management staff conduct discussions with RRDC staff via monthly conference calls regarding timely submission of service plans and LOC assessments.

NYSDOH includes specific objectives and deliverables in the RRDC contract workplans targeted at LOC requirements. Should review of the quarterly report indicate deficiencies (e.g. number of over-due plans) a plan of correction is requested by NYSDOH waiver management staff.

Retrospective reviews of a statistically reliable sample are completed by the RRDCs on an annual basis. Trends are reviewed on a statewide and regional basis. Providers with on-going issues are required to remedy the problem or jeopardize their continued participation as a service provider for waiver services.

Service Providers are required to maintain self-monitoring systems to ensure timely submission of service plans and assessments. These systems are reviewed at survey and a plan of correction of any deficiencies is required.

ii. Remediation Data Aggregation

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

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

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- (●) **No**
- ( ) **Yes**
  Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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).

TBI waiver applicants are informed of available services and alternative care to institutional living and their right to choose to participate in the community based waiver program. This information is provided at a meeting with the Regional Resource Development Specialist (RRDS). Each waiver applicant signs a Freedom of Choice form, indicating their preference for waiver services.

The Applicant Interview Acknowledgement Form indicates what information is provided to the applicant at the time of the RRDS Interview. Item #2 states: "Information about HCBS waivers and other Medicaid services to support people in the community and my right to choose whether or not to apply at this time." This document is signed and dated by the applicant and/or Legal Guardian.

The Application for Participation Form states: "I am requesting participation in a TBI Home and Community Based Services Medicaid Waiver." This document is signed and dated by the applicant and/or Legal Guardian.

The Referral Form Outcomes section completed by the RRDC includes a checklist of referrals made to other resources such as other waivers, OPWDD, Office of the Aging, Consumer Directed Services etc.

The Waiver Participant's Rights and Responsibilities form is signed and dated by the applicant. The original document is included in the Application Packet. A copy is given to the participant to be maintained in an accessible location in the participant's home.

The UAS-NY Community Assessment presents long term care program options for the individual being assessed in addition to determining a level of care score. The outcomes identify the home and community based programs for which the individual is eligible. These program options are reviewed with the applicant/participant at the time the assessment is completed.

Individuals receiving a Notice of Decision (NOD) for issues related to the waiver are eligible for a fair hearing and, in some instances, may request aid to continue. All NODs include information regarding an individual's fair hearing rights.

The Service Coordinator (SC) is responsible for explaining to the waiver applicant/participant, the rights and responsibilities of being a waiver participant. These rights and responsibilities are reviewed with the participant at least annually, and any time that it appears the participant does not understand his/her rights or responsibilities.

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

Upon enrollment, completed Freedom of Choice forms are maintained in the waiver participant's record maintained at the RRDC and Service Coordination agency 's office and are readily retrievable if requested by CMS and/or NYSDOH waiver staff.

The Service Coordinator and the RRDS are both responsible for the safe retention of all records for at least six (6) years following termination of services.

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):
Waiver participants with limited fluency in English have access to services without undue hardship. NYS General Information System Notice 11/MA/013 dated 08/09/11 informs local departments of social services (LDSS) that NYSDOH, the Office of Children and Family Services and the Office of Temporary and Disability Assistance have developed a new language identification tool. The tool assists people who do not speak or read English proficiently to identify their primary language when seeking access to LDSS' programs. Executive Order 26 signed by New York State Governor Cuomo on October 6, 2012 ensures that language access services are implemented in a cost effective and efficient manner. A copy of the Executive Order may be found at: http://www.governor.ny.gov/executiveorder/26. In addition, NYS Executive Order #26 mandates that vital records are written in "plain language".

RRDC staff make arrangements to provide interpretation or translation services for waiver participants who require these services. This may be accomplished through a variety of means, including: employing bi-lingual staff, resources from the community (e.g. local colleges), and contracted interpreters. Non-English speaking waiver applicants/participants may bring a translator of their choice with them to meetings with waiver providers and/or the RRDS. However, waiver applicants/participants are not required to bring their own translator, and waiver applicants/participants cannot be denied access to waiver services based on an RRDC's or waiver service providers' difficulty/inability to obtain qualified translators.

Appendix C: Participant Services

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

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Respite		
Statutory Service	Service Coordination		
Extended State Plan Service	Assistive Technology Services (AT)		
Extended State Plan Service	Community Transitional Services (CTS)		
Extended State Plan Service	Environmental Modifications Services		
Extended State Plan Service	Transportation Services		
Other Service	Community Integration Counseling (CIC)		
Other Service	Home and Community Support Services (HCSS)		
Other Service	Independent Living Skills and Training Services		
Other Service	Positive Behavioral Interventions and Support Services		
Other Service	Structured Day Program Services (SDP)		
Other Service	Substance Abuse Program 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:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home

Category 2:	Sub-Category 2:
09 Caregiver Support	09011 respite, out-of-home

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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 scheduled relief to non-paid supports who provide primary care and support to a waiver participant. The service is provided in a 24-hour block of time as required.

The primary location for the provision of this service is in the waiver participant's home, but Respite services may also be provided in another non-congregate care community dwelling acceptable to the waiver participant. Receipt of respite services does not preclude a participant from receiving other services on the same day.

Payment may not be made for respite furnished at the same time when other services that include care and supervision are provided (HCSS).

Providers of the Respite services must meet the same standards and qualifications as the direct care providers of Home and Community Support Services (HCSS). All HCSS/Respite services are provided by Licensed Home Care Services Agencies (LHCSA) under Article 36 of NYS Public Health Law. All regulations governing the LHCSA are in effect for the provision of Respite services. The type of care and services supported in the service plan are also to be included in the plan for Respite Services and will be reimbursed separately from Respite Services.

Each service plan contains an approved number of annual service units a provider is authorized to deliver. The provider cannot exceed the number of approved annual hours of service contained in the service plan.

Respite Services are documented in the service plan, approved by the RRDC prior to implementation and provided by agencies approved as a provider of waiver services by NYSDOH. 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:
Respite services are provided in 24-hour blocks of time, not to exceed thirty (30) days per year.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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): LHCSA

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Agencies approved to provide Home and Community Support Services (HCSS): LHCSA
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)*:
Supervising Registered Nurse must:
(A) Be a Registered Professional Nurse licensed and currently certified to practice as a Registered Professional Nurse in New York State.
(B) Meet physical health requirements set forth by NYSDOH for employees of Licensed Home Care Services
Agencies which 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) Meet one of the following qualifications:
(1) Have at least two years satisfactory recent home health care experience
(2) Have 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
If the Registered Professional Nurse does not meet the qualifications set forth in (C1) or (C2), they must act under the supervision of a Registered Professional Nurse who meets the qualifications listed in (A) and (B) of this section and meets one of the qualifications listed in (C) of this section.

Respite Staff must:
• Be at least 18 years old;
• Be able to follow written and verbal instructions;
• Have the ability and skills necessary to meet the waiver participant's needs that will be addressed through this service;
• Meet physical health requirements set forth by NYSDOH for employees of Licensed Home Care

Services
Agencies which 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;
• Have a valid certificate to indicate successful completion of a forty (40) hour training program for
Level II PCA or PCA Alternate Competency Demonstration equivalency testing that is approved by NYSDOH
• Attend six (6) hours of in-service education per year
• Respite providers are required to be a Licensed Home Care Service Agency (LHCSA), HCSS aides must
be supervised by a Registered Professional Nurse (licensed by the NYS Education Department) in
compliance with Licensed Home Care Service Agency (LHCSA) regulations;
• Staff must meet the requirements of Title 10 NYCRR 766.11 Personnel and have completed a criminal
history check to the extent required by section 10 NYCRR 400.23; Program staff must act under the
direction of an individual who meets the qualifications listed in (A), (B), and one of the
qualifications listed in (C) of this section.

Verification of Provider Qualifications

Entity Responsible for Verification:
NYSDOH waiver management staff and its contractors (RRDCs) at the time of enrollment. For employer-employee the employer is responsible for verifying that that the individuals 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH 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:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):
Service Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management

Category 2:	Sub-Category 2:

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

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

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

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

Service Definition *(Scope):*
Service Coordination is an individually designed service which provides primary assistance to the waiver applicant/participant in gaining access to needed waiver and Medicaid State Plan services, as well as other local, state, and federally funded educational, vocational, social, and medical services. The Service Coordinator assists the applicant in becoming a waiver participant and coordinates and monitors the provision of all services in the service plan once the individual is determined eligible. For individuals transferring from nursing facilities, the Service Coordinator assists the applicant in obtaining and coordinating services that are necessary to return to the community. For those individuals residing in the community, the Service Coordinator facilitates the necessary supports to maintain the individual's health and well-being sufficient to avoid unwanted nursing home placement.

There are two types of Service Coordination provided to the participant:
1. Service Coordination, Initial: Encompasses those activities involved in assisting individuals seeking application for waiver services and developing the documentation included in the Application Packet. Providers may only bill for this service upon the person's entry into the waiver. This service is paid one time per admission to the TBI waiver.

2. Service Coordination, Monthly: Ongoing Service Coordination begins as soon as the individual is determined eligible for waiver services. The Service Coordinator is responsible for the timely and effective implementation of the approved service plan. The Service Coordinator is responsible for assuring that there is adequate coordination, effective communication, and maximum cooperation between all sources of support and services for the participant. This type of service coordination is provided to waiver participants on an ongoing, monthly basis.

The Service Coordinator is responsible for:
- Facilitating the Initial Service Plan (ISP) and waiver program eligibility
- Coordinating multiple services among multiple providers
- Securing initial and annual level of care assessments
- Assuring that Team Meetings are scheduled and held as designated in the service plan
- Facilitating the acquisition, oversight, and delivery of service
- Ensuring annual service plans (Revised Service Plans/RSPs) are completed in a timely manner
- Facilitating the waiver applicant/participant's Plan of Protective Oversight (PPO) is completed and supports the service plan
- Conducting monthly face to face visits and in-home visits with the participant no less than once a quarter
- Maintaining records for at least six (6) years after termination of waiver services
- Responding to participant crises and emergencies
- Addressing problems in service provision

Each year the Service Coordinator will develop and submit the annual service plan or Revised Service Plan (RSP).

The Service Coordinator is responsible for the development of the service plan. The service plan contains an assessment of the individual's strengths, limitations, and goals. It identifies what services are necessary to maintain the individual in the community. The plan must include current summaries of all services provided, including relevant medical information and assessments. The Service Coordinator does not conduct initial and annual LOC assessments. Contained within the service plan the Service Coordinator must provide a detailed explanation of the applicant's/participant's choices and needs, including information regarding relationships, desired living situation, recreation or community activities, physical and mental strengths or limitations, and goals for vocational training,

and employment or community service. A description of why the waiver services are needed to prevent placement in a nursing home must also be included. The service plan identifies services at twelve month intervals. The Service Coordinator is responsible for ensuring that the participant and all service providers receive a copy of the approved service plan and are aware of the content of the overall plan and goals. Services in a service plan cannot be initiated until prior approval is given by the RRDC; service changes or additions proposed in a Revised Service Plan (RSP) cannot be initiated without prior approval from the RRDC

A Service Coordinator must be knowledgeable about all waiver services, Medicaid State Plan services, and non-Medicaid services. Informal supports are often a crucial factor if the participant is to live a satisfying life and remain in the community. The Service Coordinator must be skilled in incorporating all of these resources into the waiver participant's service plan.

The Service Coordinator is responsible for assisting the waiver participant in the development of the individualized service plan and assuring that the participant, and those individuals chosen by the participant, are involved in the process.

The Service Coordinator is responsible for coordinating Team Meetings. Team Meetings must be coordinated and facilitated by the Service Coordinator and must occur, at a minimum, every six (6) months and when a Revised Service Plan is developed. Team Meetings are scheduled based on the service needs of the participant. At the meeting, the Service Coordinator must discuss with the participant and other participating individual(s) any proposed changes to the participant's existing service plan. Service Coordinators will continue to coordinate team meetings.

The Service Coordinator is responsible for the timely submission and distribution of all service plans and for the ongoing monitoring of services identified and approved in the participant's service plans.

The Service Coordinator initiates and secures the initial and annual re-evaluations 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 application.

A Service Coordinator's caseload may not exceed twenty-five (25) TBI waiver participants. The Service Coordinator must complete a monthly face to face visit with each TBI waiver participant on their caseload. They must meet with the participant in their home at least quarterly.

All Service Coordination services must be documented in the service plan and provided by individuals or agencies approved as a provider of wavier services by NYSDOH.

All agencies employing two (2) or more Service Coordinators must provide supervision by an individual who fully meets the qualifications as a Service Coordinator. The supervisor is expected to meet any waiver participants prior to the completion of the Revised Service Plan (RSP) developed by a Service Coordinator under their supervision, have supervisory meetings with staff on at least a monthly 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.

The provision of Service Coordination under this waiver is cost effective and necessary to avoid institutionalization. This service does not duplicate other services available through the New York Medicaid State Plan. The cost effectiveness of this service is demonstrated in Appendix J.

Any provider currently providing Service Coordination Services approved pursuant to the qualifications in the waiver dated 4/1/08-6/30/13 is "grandfathered-in" and approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

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

Initial Service Coordination is paid one time per admission to the TBI waiver.

A Service Coordinator's caseload may not exceed twenty (25) TBI waiver participants. The Service Coordinator must complete a monthly face to face visit with each TBI waiver participant on their caseload. They must meet with the participant in their home at least quarterly.

NYSDOH is in the process of preparing to transition all service coordination functions into a structure that is compliant with Conflict of Interest standards.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Independent Provider
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: Statutory Service
Service Name: Service Coordination

Provider Category:
Individual

Provider Type:
Independent Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Persons self-employed as Service Coordinators must be a/an:

1. Licensed Master Social Worker (LMSW- licensed by the NYS Education Department);
2. Licensed Clinical Social Worker (LCSW- licensed by the NYS Education Department);
3. Individual with a Doctorate or Master of Social Work degree;
4. Individual with a Doctorate or Master of Psychology degree;
5. Licensed Physical Therapist (licensed by the NYS Education Department);
6. Registered Professional Nurse (licensed by the NYS Education Department);
7. Certified Teacher of Students with Disabilities (certified by the NYS Education Department);
8. Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification);
9. Licensed Speech Pathologist (licensed by the NYS Education Department);
10. Licensed Occupational Therapist (licensed by the NYS Education Department);

AND
Must have, at a minimum, one (1) year of experience providing case management/service coordination, information and referral services and service brokering of community based services for individuals with disabilities and/or Traumatic Brain Injury;

OR

Individual with a Bachelor's degree and three (3) years of experience providing case management/service coordination, information and referral services and service brokering of community based services for individuals with disabilities and/or Traumatic Brain Injury.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH waiver management staff and its contractors (RRDCs) at the time of 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 NYSDOH waiver management staff and/or its contractors (RRDC). NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH surveys and/or audits.

Any provider currently providing Service Coordination approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

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/an:

1. Licensed Master Social Worker (LMSW- licensed by the NYS Education Department);
2. Licensed Clinical Social Worker (LCSW- licensed by the NYS Education Department);
3. Individual with a Doctorate or Master of Social Work degree;
4. Individual with a Doctorate or Master of Psychology degree;
5. Licensed Physical Therapist (licensed by the NYS Education Department);
6. Registered Professional Nurse (licensed by the NYS Education Department);
7. Certified Teacher of Students with Disabilities (certified by the NYS Education Department);
8. Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification);
9. Licensed Speech Pathologist (licensed by the NYS Education Department);
10. Licensed Occupational Therapist (licensed by the NYS Education Department);

AND

Must have, at a minimum, one (1) year of experience providing case management/service coordination, information and referral services and service brokering of community based services for individuals with disabilities and/or Traumatic Brain Injury;

OR

Individual with a Bachelor's degree and three (3) years of experience providing case management/service coordination, information and referral services and service brokering of community based services for individuals with disabilities and/or Traumatic Brain Injury.

All agencies that employ two (2) or more Service Coordinators must provide supervision by an individual who fully meets the qualifications as a Service Coordinator.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH waiver management staff and its contractors (RRDCs) at the time of enrollment. For employer-employee the employer is responsible for verifying that that the individuals 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH surveys and/or audits.

Any provider currently providing Service Coordination approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

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/an:

1. Licensed Master Social Worker (LMSW- licensed by the NYS Education Department);
2. Licensed Clinical Social Worker (LCSW- licensed by the NYS Education Department);
3. Individual with a Doctorate or Master of Social Work degree;
4. Individual with a Doctorate or Master of Psychology degree;
5. Licensed Physical Therapist (licensed by the NYS Education Department);
6. Registered Professional Nurse (licensed by the NYS Education Department);
7. Certified Teacher of Students with Disabilities (certified by the NYS Education Department);
8. Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification);
9. Licensed Speech Pathologist (licensed by the NYS Education Department);
10. Licensed Occupational Therapist (licensed by the NYS Education Department);

AND

Must have, at a minimum, one (1) year of experience providing: case management/service coordination,

information and referral services and service brokering of community based services for individuals with disabilities and/or Traumatic Brain Injury;

OR

Individual with a Bachelor's degree and three (3) years of experience providing case management/service coordination, information and referral services and service brokering of community based services for individuals with disabilities and/or Traumatic Brain Injury.

All agencies that employ two (2) or more Service Coordinators must provide supervision by an individual who fully meets the qualifications as a Service Coordinator.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH waiver management staff and/or its contractors (RRDCs) 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications and certifications through NYSDOH surveys and/or audits.

Any provider currently providing Service Coordination approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

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:

Extended State Plan Service

Service Title:

Assistive Technology Services (AT)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology

Category 2:	Sub-Category 2:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

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

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

Assistive Technology Services (AT) supplement State Plan Medicaid Services for Durable Medical Equipment and Supplies and offers medical devices and supplies not available under the State Plan. Medicaid State Plan and all other resources must be utilized before considering a request for Assistive Technology. All other sources must be explored utilized and/or exhausted before seeking Assistive Technology services.

Assistive Technology includes the costs associated with acquisition of the assistive technology, the evaluation of the assistive technology needs of a participant, implementation and oversight of the technology, including a functional evaluation of the impact of the provision of appropriate assistive technology to the participant in the customary environment of the participant and/or the services consisting of the selecting, designing, project management, fitting, customizing, adapting, maintaining, repairing, or replacing Assistive Technology devices. In addition, the service may provide for training or technical assistance for the participant, family members, guardians, paid staff, advocates, or others who are utilizing or assisting with the implementation of the technology.

This service is only approved when the requested equipment and supplies are deemed medically necessary, and/or directly contribute to the participant's level of independence, ability to access needed supports and services in the community, or are expected to maintain or improve the participant's safety and/or functional limitations as specified in the participant's service plan. The service includes the performance of assessments to identify the type of equipment needed by the participant.

Justification for the Assistive Technology must indicate how the specific service/device will meet the medical and/or other needs of the participant in the most cost effective manner.

Assistive Technology may be obtained at the time the individual becomes enrolled as a participant, no more than thirty days in advance of community placement from a nursing home (prior to the initial NOD), or at the time of an approved service contained within a service plan. Requests for Assistive Technology must be less than $35,000 per two (2) year period, unless approved by NYSDOH waiver management staff.

Requests for service must include all assessments made to identify the necessary Assistive Technology, including an assessment of the participant's unique functional needs, the intended purpose and expected use of the requested Assistive Technology, and documentation that the identified need has been matched to the features of the products requested to assure the desired outcome. Justification must show how and why the service or product is needed and what rehabilitative or sustaining function it serves. It is anticipated that equipment loan programs or trial periods of non-customized equipment, if available, may be explored before extensive commitments are made to provide/purchase products.

Assistive Technology also includes Personal Emergency Response Systems (PERS) that are not supported through state plan services: home devices that connect the person to a 24-hour call center with the push of a button. PERS are utilized as an integral part of a Medicaid personal care plan and is used to supplement waiver services. If this service is billed to Medicare or private insurance, the individual will not be eligible for PERS services through Assistive Technology.

Reimbursement is one hundred percent (100%) of the approved cost payable to the AT provider for coordinating the purchases on behalf of the participant.

Assistive Technology must be documented in the Service Plan, approved by the RRDC and provided by agencies approved by NYSDOH waiver management staff. The cost effectiveness of this service is demonstrated in Appendix J.

Any provider currently providing Assistive Technology Services approved pursuant to the qualifications in the

waiver dated 4/1/08-6/30/13 is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

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

For Assistive Technology costing up to $2,000, only one bid is required.
For Assistive Technology costing $2,000 or more, three bids are required.

Limit of up to $35,000 per two year period unless a request for Assistive Technology in the amount of $35,000 or more has been approved by NYSDOH waiver management staff.
Due to the needs of the target population, provisions contained within this service allow for costs that exceed CFCO state plan services.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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
Agency	Licensed Pharmacy
Agency	Approved providers of PERS

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Assistive Technology Services (AT)

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 that has both the personnel and expertise to provide Assistive Technology and is an approved Medicaid provider may provide Assistive Technology or may subcontract with a qualified person or entity to provide Assistive Technology.

Verification of Provider Qualifications

Entity Responsible for Verification:
NYSDOH 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications and certifications through NYSDOH surveys and/or audits.

Any provider currently providing Assistive Technology approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Assistive Technology Services (AT)

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 that has both the personnel and expertise to provide Assistive Technology and is an approved Medicaid provider may provide Assistive Technology or may subcontract with a qualified person or entity to provide Assistive Technology.
Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications and certifications through NYSDOH surveys and/or audits.

Any provider currently providing Assistive Technology approved pursuant to the qualifications in the waiver is approved prior to the most recent approval to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Assistive Technology Services (AT)

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:
NYSDOH waiver staff and/or its contractors for provider (practitioner) credentials at the time of provider enrollment.
Frequency of Verification:
Upon signed provider agreement. The waiver service provider reports any subsequent change in status to NYSDOH waiver management staff and/or its contractors (RRDC). NYS Office of the Medicaid Inspector General (OMIG) staff verify employee qualifications upon audit.

Any provider currently providing Assistive Technology approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Assistive Technology Services (AT)

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:
NYSDOH 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire. NYSDOH Office of the Medicaid Inspector General (OMIG) staff verify employee qualifications upon audit.

Any provider currently providing Assisitive Technology approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

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:
Extended State Plan Service

Service Title:
Community Transitional Services (CTS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

Community Transitional Services (CTS) are defined as individually designed services and project management intended to assist a waiver participant in transitioning from a nursing home to living in the community. CTS is a one-time service per waiver enrollment. If the waiver participant is discontinued from the program and re-enters a nursing home, they can access this service again upon discharge. This service is only provided when transitioning

from a nursing home. These funds are not available for moves from the participant's home in the community to another location in the community.

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

Security deposits funded through this service and returned upon vacating the residence or dwelling must be returned to the CTS provider. Upon return of the funds, the CTS provider must submit a paid claim void to eMedNY.

The service will not be used to purchase recreational items, such as televisions, DVD players or music systems.

Approved costs are covered by CTS up to thirty (30) days prior to the individual's discharge from the nursing home into the community. Reimbursement is one hundred percent (100%) of the approved cost.

All CTS expenses must be included in the approved Initial Service Plan and provided by agencies approved by NYSDOH. Reimbursement is not provided for items purchased prior to RRDS approval.

Any provider currently providing Community Transitional Services approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers and staff not meeting the new qualifications will sunset when a staff person terminates employment with the agency they were employed prior to the new criteria.

Community Transitional Services must be documented in the Service Plan, approved by the RRDC and provided by agencies approved by NYSDOH 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:
Maximum up to $8000 per waiver enrollment.
Due to the needs of the target population, provisions contained within this service allow for costs that may exceed CFCO state plan services.

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
Agency	Not for Profit Housing Agency or Local Housing Authority
Agency	Licensed Pharmacy

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Community Transitional Services (CTS)

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 that has both the personnel and expertise to provide the Community Transitional Services and is an approved Medicaid provider may provide Community Transitional Services or may subcontract with a qualified person or entity to provide Community Transitional Services.

There are no minimum staff qualifications to provide Community Transitional Services. The qualifications are specific to the licensure and registration of the provider agency as a whole.
Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH waiver management staff and its contractors (RRDCs) at the time of enrollment. For employer-employee the employer is responsible for verifying that that the individuals 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire. NYSDOH Office of the Medicaid Inspector General (OMIG) staff verify employee qualifications upon audit.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Community Transitional Services (CTS)

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 that has both the personnel and expertise to provide the Community Transitional Services and is an approved Medicaid provider may provide Community Transitional Services or may subcontract with a qualified person or entity to provide Community Transitional Services.

There are no minimum staff qualifications to provide Community Transitional Services. The qualifications are specific to the licensure and registration of the provider agency as a whole.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH surveys and/or audits.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Community Transitional Services (CTS)

Provider Category:

Agency

Provider Type:

Not for Profit Housing Agency or Local Housing Authority

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Any not for profit housing agency or local housing authority that has both the personnel and expertise to provide the Community Transitional Services may provide Community Transitional Services or may subcontract with a qualified person or entity to provide Community Transitional Services.

A not for profit housing agency or local housing authority upon application is eligible to provide CTS services.

There are no minimum staff qualifications to provide Community Transitional Services. The qualifications are specific to the licensure and registration of the provider agency as a whole.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH waiver management staff and its contractors (RRDCs) at the time of enrollment. For employer-employee the employer is responsible for verifying that that the individuals maintain the needed license or certification.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider reports any subsequent change in status to NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH surveys and/or audits.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Community Transitional Services (CTS)

Provider Category:
Agency
Provider Type:
Licensed Pharmacy
Provider Qualifications
License *(specify):*
An establishment registered as a pharmacy by the State Board of Pharmacy pursuant to Article 137 of the NYS Education Law
Certificate *(specify):*

Other Standard *(specify):*
There are no minimum staff qualifications to provide Community Transitional Services. The qualifications are specific to the licensure and registration of the provider agency as a whole.
Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH 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:
Extended State Plan Service
Service Title:
Environmental Modifications Services

HCBS Taxonomy:

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

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

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

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

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 include the performance of necessary assessments and project management to determine the type of modifications needed and the assessment that the adaptation has been completed according to the required specifications.

Repairs for home modifications which are medically necessary, support the waiver participant's independence in the home or community, and that are cost effective may be allowed. Repair and/or replacement of environmental modifications must be contingent upon developing and implementing a plan to minimize repeated damage.

An E-mod may alter the basic configuration of the waiver participant's home if this alteration is necessary to successfully complete the modification. However, the modification cannot be used to increase the square footage of the home.

For individuals transitioning from a nursing facility, E-mods may be initiated up to thirty (30) days prior to the initial Notice of Decision (NOD)/discharge from the facility and reimbursed after the Notice is issued.

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. All modifications must meet State and local building codes.

For modifications with an estimated cost for $5,000.00 or more a Home Evaluation is required. The evaluation is completed in three phases:
Initial: The home evaluator visits the home to identify the current needs of the participant and any potential safety issues. The evaluator also assesses the structure of the home in order to identify any potential issues that may hinder the completion of the E-mod project. The home evaluator determines the specifications of the adaptation/modification.

Mid Project: The home evaluator visits the home to monitor the implementation of the project to ensure adequate progress is being made and to assess for any additional safety or functional issues.

Final: The final home visit is conducted at the completion of the project. The home evaluator inspects the project to ensure all E-mods are completed and accessible to the participant. This visit is required before payment is released to the service provider.

With the approval of the home evaluator and RRDC, payments may be made in three increments: 1) upon execution of the contract, 2) half way through the completion of the project, and 3) upon completion of the project and approval of the project by the RRDC and Home Evaluator. All phases of a home modification must be inspected and approved by the Home Evaluator and/or RRDC or NYSDOH staff prior to payment.

Vehicle modifications provide the participant with the means to access services and supports in the community, increase independence and promote productivity. These modifications may include adaptive equipment and/or vehicle modifications.

Modifications are made to a vehicle if it is the primary means of transportation for the waiver participant and is available to the participant without restrictions. This vehicle may be owned by the waiver participant; a family member who has consistent and ongoing contact with the waiver participant; or a non-relative who provides primary, long term support to the waiver participant.

These modifications are approved only when the vehicle is used to improve the waiver participant's independence and inclusion in the community. Upkeep and maintenance of the modifications/adaptations made to the vehicle may be included in this waiver service with the approval of the RRDS, but does not include the routine maintenance of the vehicle.

All vehicles modified under the waiver must be insured (collision and comprehensive) and meet New York State inspection standards before and after the modifications are completed. NYSDOH is the payer of last resort. Any insurance claim for replacement equipment must be exhausted prior to seeking this waiver service.

Equipment that is available from the dealer by factory installation as standard or optional features of the car is not reimbursable as a waiver service. These items, as well as routine maintenance and repair of the vehicle, are the responsibility of the participant.

Modifications may not exceed the Blue Book or current market value of the vehicle. The value of the vehicle at the time of the modification must be equal or more than the cost of the modification.

The vehicle must be inspected by the RRDC prior to the approval of the modification request and upon completion of the modification.

The vehicle must be structurally sound and not in need of mechanical repairs.

The vehicle must not have any rust or deficiencies in the areas to be modified or in the areas already modified.

The vehicle must be less than five years old or register less than 50,000 miles.

Adaptive equipment and vehicle modifications may only be provided if the following conditions are met:

a. The participant is not eligible for these services through any other resource (e.g., ACCES-VR, Veterans Administration, Workers Compensation, insurances, etc.);

b. There is an acceptable written recommendation and justification by an ACCES-VR approved evaluator/Driver Habilitation Specialist indicating the modification is essential for the participant to drive or be transported in a motor vehicle; and the participant and the owner of the vehicle must sign the statement, indicating that the vehicle is available to the participant without restrictions.

Reimbursement is not provided for vehicle modifications completed prior to RRDS inspection and approval and without the written recommendations of a Driver Habilitation Specialist.

This service does not include general repairs or maintenance of a vehicle. All warranties and guarantees associated with the vehicle and adaptive device(s) must be fully utilized prior to seeking this service. Requests for repairs to E-mods for the vehicle must follow the same procedure as initial vehicle modification applications. This service will only support replacement items for damages beyond normal wear and tear.

Reimbursement will not be provided for modifications completed prior to RRDS approval.

Any provider currently providing Environmental/Vehicle Modification Services approved pursuant to the qualifications in the waiver dated 4/1/08-6/30/13 is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers and staff not meeting the new qualifications will sunset when a staff person terminates employment with the agency they were employed prior to the new criteria.

All E-mods and vehicle modifications must be documented in the Service Plan and provided by agencies approved by DOH Waiver Management Staff. 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:

E-mod and Vehicle modifications must be less than $45,000 per thirty-six (36) month period, unless approved by NYSDOH.

Home Evaluation services may not exceed ten percent (10%) of the total cost of the project.

Driver Rehabilitation Specialist services may not exceed ten percent (10%) of the total cost of the project.

Any request for a modification with a total cost of $15,000 or more requires prior approval from NYSDOH.

For E-mod and Vehicle modifications costing up to $2,000, only one bid is required. All bids must be completed using the Waiver Program bid form.

For E-mod and Vehicle modifications costing $2,000 or more, three bids are required. All bids must be completed using the Waiver Program bid form.

Due to the needs of the target population, provisions contained within this service allow for costs that may exceed CFCO state plan services.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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
Agency	Not for profit Housing Agency or Local Housing Authority

Appendix C: Participant Services

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

Service Type: Extended State Plan 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 that has both the personnel and expertise to complete the E-mod and is an approved Medicaid provider may provide Environmental Modifications or may subcontract with a qualified person or entity to provide Environmental Modifications.

Persons employed/contracted as a home evaluator must be a:

1. Certified Aging in Place Specialist and have experience in recommending and implementing assistive technology or durable medical equipment in the home health care domain;
2. Certified Environmental Access Consultant in the field of environmental modification with experience in recommending and implementing assistive technology or durable medical equipment in the home health care domain;
3. Licensed Occupational Therapist (licensed by NYS Education Department);
4. Universal Design/Barrier Free/Accessibility Specialist;
5. An independent contractor with expertise in universal design; or
6. Licensed Physical Therapist (licensed by NYS Education Department);

Persons employed/contracted as a Driver Rehabilitation Specialist must be one of the following:

1. Approved as a Driver Rehabilitation Specialist by Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR);
2. Licensed Occupational Therapist (Licensed by the NYS Education Department);
3. Licensed Physical Therapist (Licensed by the NYS Education Department); or
4. An individual with a Bachelor's degree certified as a Certified Driver Rehabilitation Specialist under the auspices of the Association of Driver Rehabilitation Specialists (ADED).

The Emod provider must ensure that individuals working on the Emod are appropriately qualified and/or licensed to comply with any state or local rules. All materials and products used must meet any state and 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 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee/subcontractor, the hiring agency must verify license or certification upon hire. NYSDOH Office of the Medicaid Inspector General (OMIG) staff verify employee qualifications upon audit.

Any provider currently providing Emod services approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

Appendix C: Participant Services

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

Service Type: Extended State Plan 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 that has both the personnel and expertise to complete the E-mod and is an approved Medicaid provider may provide Environmental Modifications or may subcontract with a qualified person or entity to provide Environmental Modifications.

Persons employed/contracted as a Home Evaluation Specialist must be a:

1. Certified Aging in Place Specialist and have experience in recommending and implementing assistive technology or durable medical equipment in the home health care domain;
2. Certified Environmental Access Consultant in the field of environmental modification with experience in recommending and implementing assistive technology or durable medical equipment in the home health care domain;
3. Licensed Occupational Therapist (licensed by NYS Education Department);
4. Universal Design/Barrier Free/Accessibility Specialist;
5. An independent contractor with expertise in universal design; or
6. Licensed Physical Therapist (licensed by NYS Education Department).

Persons employed/contracted as a Driver Rehabilitation Specialist must be one of the following:

1. Approved as a Driver Rehabilitation Specialist by Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR);
2. Licensed Occupational Therapist (Licensed by the NYS Education Department);
3. Licensed Physical Therapist (Licensed by the NYS Education Department); or
4. An individual with a Bachelor's degree certified as a Certified Driver Rehabilitation Specialist under the auspices of the Association of Driver Rehabilitation Specialists (ADED).

In addition, the individual must document three (3) years of experience providing driver rehabilitation services as defined by ACCES-VR.

The Emod provider must ensure that individuals working on the Emod are appropriately qualified and/or licensed to comply with any state or local rules. All materials and products used must meet any state and 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 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). For Employer-Employee/subcontractor, the hiring agency must verify license or certification upon hire. NYSDOH Office of the Medicaid Inspector General staff verify employee qualifications upon audit.

Any provider currently providing Emod services approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Environmental Modifications Services

Provider Category:
Agency
Provider Type:
Not for profit Housing Agency or Local Housing Authority
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Any not for profit Housing Agency or Local Housing Authority that has both the personnel and expertise to complete the E-mod as an approved Medicaid provider may provide Environmental Modifications or may subcontract with a qualified person or entity to provide Environmental Modifications.

Persons employed/contracted as a Home Evaluation Specialist must be a:
1. Certified Aging in Place Specialist and have experience in recommending and implementing assistive technology or durable medical equipment in the home health care domain;
2. Certified Environmental Access Consultant in the field of environmental modification with experience in recommending and implementing assistive technology or durable medical equipment in the home health care domain;
3. Licensed Occupational Therapist (licensed by NYS Education Department);
4. Universal Design/Barrier Free/Accessibility Specialist;
5. An independent contractor with expertise in universal design; or
6. Licensed Physical Therapist (licensed by NYS Education Department).

Persons employed/contracted as a Driver Rehabilitation Specialist must be one of the following:

1. Approved as a Driver Rehabilitation Specialist by Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR);
2. Licensed Occupational Therapist (Licensed by the NYS Education Department);
3. Licensed Physical Therapist (Licensed by the NYS Education Department); or
4. An individual with a Bachelor's degree certified as a Certified Driver Rehabilitation Specialist under the auspices of the Association of Driver Rehabilitation Specialists (ADED).

In addition, the individual must document three (3) years of experience providing driver rehabilitation services as defined by ACCES-VR.

The Emod provider must ensure that individuals working on the Emod are appropriately qualified and/or licensed to comply with any state or local rules. All materials and products used must meet any state and 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 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee/subcontractor, the hiring agency must verify license or certification upon hire. NYSDOH Office of the Medicaid Inspector General staff verify employee qualifications upon audit.

Any provider of Emod serives approved pursuant to the qualifications in the waiver dated 4/1/08-6/30/13 is approved to provide services under the new application. New employees/providers are

required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

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:

Extended State Plan Service

Service Title:

Transportation Services

HCBS Taxonomy:

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

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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):*

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

Transportation is offered as a direct service to waiver participants in order to enable individuals to gain access to identified community resources, other community services, and activities as specified in their 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. It includes transportation for non-medical activities, which support the participant's integration into the community. All other options for transportation, such as informal supports, and community services that provide this service without charge are utilized prior to seeking this service. The least costly and most medically appropriate mode of transportation is utilized.

NYSDOH 96 Local Commissioners Memorandum (LCM) -37 states: If there is an established need for transportation to and from non-medical services, activities or events, the waiver participant and the Service Coordinator must first explore the use of informal supports to provide the transportation without charge and the use

of existing transportation. If these are not viable options, transportation may be included in the participant's service plan as a waiver service.

Waiver transportation services/locations are subject to NYSDOH prior approval. A description of required social transportation services is included in each participant's service plan. The RRDC approves the total number of annual units of trips and destinations as part of the service plan approval. The trip cost is derived from NYS approved Medicaid transportation rates and may be a calculation of a base rate, approved mileage and other approved NYS costs. NYSDOH contracts with a transportation provider to arrange and provide services. The Transportation Manager will use the Grid included in the service plan coupled with Medicaid transportation policies to arrange travel as appropriate.

Transportation services are administered by a contracted Medicaid Transportation Manager. When a friend or family member is available to transport a waiver participant, this friend or family member should be used for social transportation. Within reason, the same mode of transportation used by the waiver participant for standard medical trips should be used for social trips. The most cost effective means of transportation needs to be considered. The mode of transportation should support the needs of the participant identified in the service plan.

Waiver transportation is available to all persons enrolled in the waiver program where providers are available. A determination must be made by the appropriate prior authorization official prior to utilizing this service. Prior approval by NYSDOH and the RRDC must be obtained for all identified trips contained within the service plan. Transportation will only be available to a location that is identified in the service plan and/or the approved transportation service request grid and is directly related to functional needs and/or goals identified in the service plan. Each service plan should identify the common market area commutation. Travel outside the common marketing area can be allowed when acceptable justification is presented. The Service Coordination agency is ultimately responsible to ensure that the travel identified in a waiver participant's individualized service plan is an appropriate and judicious use of public funds. Reimbursement for travel can be denied when the prior authorization official determines that the destination does not support the participant's integration into the community. The RRDS approves the service and the service limits with the approval of the plan. The RRDS needs to maintain an open line of communication with the Transportation Contractor and Service Coordinator to discuss usage and appropriateness of the request. The prior authorization official can always request additional information from the service coordinator to assist with the decision to approve or disapprove the request for social transportation services.

The need for transportation must be documented in the service plan. Whenever possible, family members, neighbors, friends or community agencies which can provide this service without charge will be utilized. A waiver participant's service plan outlines the general parameters of his or her social transportation needs. However, these needs can change or be amended based upon the waiver participant's stated goals and/or successful ongoing integration into the community.

Transportation providers will only be reimbursed when acceptable records verifying a trip's occurrence are complete and available to auditors upon request. All payments are made through eMedNY as authorized by the Medicaid Transportation Contractor.

Payment is not made for waiver transportation if the participant does not receive prior authorization for the transport. Prior authorization is obtained from the contracted Medicaid Transportation Manager and must be included in the service plan and approved by the RRDC.

All documentation is reviewed by the Service Coordinator prior to submission to the RRDC and Transportation Management Contractor.

The Service Coordination agency is ultimately responsible to ensure that the travel identified in a waiver participant's approved service plan is an appropriate and judicious use of public funds.

Reimbursement for travel is denied when the prior authorization official determines that the destination does not support the participant's integration into the community and is not reflected in the service plan.

Requests for service are submitted to the RRDC and upon approval by the RRDC is forwarded to the Transportation Management Contractor.

All waiver transportation services are documented in the service plan and provided by providers approved by the New York State Department of Health and/or its contractors.

The Service Coordinator, RRDC and the Transportation Contractor are responsible for maintaining complete and current records related to the request and provision of waiver transportation services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The duration of the service should be specified in the participant's service plan. Social Transportation may be used to help initiate a new activity or skill for a participant. An individual may also use social transportation for a reoccurring activity if it is detailed in their service plan; however the time frame and frequency for using transportation in this capacity must be outlined. There must be an articulated frequency and start and endpoint for using social transportation to achieve a specific goal. Once the specific goal is met, the service for that activity should be discontinued. If the participant has more than one goal in his or her service plan that includes the use of social transportation, it is reasonable to expect a participant to complete their needs tied to each goal in the same location if possible on the same day during the week.

Before a transport is provided to a waiver participant, the transportation provider verifies the person's eligibility for Medicaid on the date of service. Reimbursement is not made for services rendered to ineligible persons. The Service Coordinator and/or RRDC must consult the Transportation Management Contractor prior to requesting a trip. Trip cost is derived from using the NYS Fee schedule at http://www.emedny.org/ProviderManuals/Transportation/index.html.

Due to the needs of the target population, provisions contained within this service allow for services that may exceed CFCO state plan services.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Common Carrier & specialized transportaion

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Transportation Services

Provider Category:
Agency
Provider Type:
Common Carrier & specialized transportaion
Provider Qualifications
License *(specify):*
To participate in the New York State Medicaid Program, a provider must meet all applicable State, County and Municipal requirements for legal operation.
Department regulation at Title 18 of the New York Code of Rules and Regulations (NYCRR) Section 505.10, which applies to Medicaid transportation services, can be found at: http://www.health.ny.gov/regulations/nycrr/title_18/.
Title 18 NYCRR §505.10(e)(6) indicates that providers must, regardless of Medicaid enrollment status, comply with applicable regulatory requirements. For ambulette, taxi and livery companies, this may include local licensure by a municipality or a Taxi and Limousine Commission.
Certificate *(specify):*

Other Standard *(specify)*:
Any currently approved provider of State Plan Medicaid Transportation is eligible to provide HCBS/TBI waiver transportation.
https://www.emedny.org/ProviderManuals/Transportation/PDFS/Transportation_Manual_Policy_Section.pdf

Verification of Provider Qualifications

Entity Responsible for Verification:
NYSDOH Office of Health Insurance Programs Medicaid Transportation Unit

Frequency of Verification:
Qualifications are verified on an on-going basis by the Medicaid Transportation contractor and monitored by the Medicaid Transportation Unit.

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 (CIC)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling

Category 2:	Sub-Category 2:
10 Other Mental Health and Behavioral Services	10070 psychosocial rehabilitation

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

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

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

Community Integration Counseling (CIC) is an individualized counseling service designed to assist the waiver participant to effectively manage the emotional difficulties associated with adjusting to life after a traumatic brain injury. It is a counseling service provided to a participant coping with the need to revise long term expectations, his/her changing roles, and the impact of these changes on him/her, family members and informal supports. This service is provided in the provider's office or the participant's home. It is available to participants and/or anyone involved in an ongoing significant relationship with the consent of the participant when the issues discussed relate directly to the participant. The participant must be present (face to face) at the time of service delivery. "Collateral counseling" is not permitted without the participant present. Regarding client confidentiality, the sharing of information obtained during a CIC session can only be disclosed in accordance with accepted professional standards regarding client confidentiality.

The service is designed for individuals experiencing significant problems in managing the emotional difficulties inherent in adjusting to a significant disability and living in the community. The efficacy of a treatment must be reviewed if successful intervention and significant progress has not occurred within two (2) years. At that time alternative methods require consideration or continued services must be documented as a medical necessity. Prior to the termination of services a transition plan will be implemented. Services may be extended in extraordinary cases with sufficient medical justification and upon review and approval of the RRDC.

While CIC Services are primarily provided in a one-to-one counseling session, there are times when it is appropriate to provide this service to the waiver participant in a family counseling or group counseling setting. The participant must be present at all CIC sessions.

CIC must not be used to assist the participant to become physically integrated into his/her environment. This function is the responsibility of other service providers, such as Service Coordination, ILST and HCSS.

This service does not duplicate other services available through the New York Medicaid State Plan. Therefore, once the counseling is no longer specific to community integration and becomes general therapeutic counseling, the service will terminate. Upon initiation of the service, an initial assessment must be completed and include specific counseling goals.

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

Any provider currently providing Community Integration Counseling Services approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

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

Upon initiation of the service, as a transition service, an initial assessment must be completed. The assessment indicates the proposed number of hours of service and justifies the need for the service. The assessment is limited to five (5) hours of direct service with the participant present. Goals must be reasonable and attainable and services do not extend beyond a two-year period.

Prior to the termination of services a transition plan will be implemented. Services may be extended in extraordinary cases with sufficient justification and upon review and approval of the RRDC.

Services may not exceed 220 hours annually/4 hours weekly.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 (CIC)

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 a Community Integration Counselor must be a/an:

1. Licensed Psychiatrist (licensed by the NYS Education Department);
2. Licensed Psychologist (licensed by the NYS Education Department);
3. Licensed Master Social Worker (LMSW- licensed by the NYS Education Department);
4. Licensed Clinical Social Worker (LCSW- licensed by the NYS Education Department);
5. Individual with a Doctorate degree in Psychology;
6. Licensed Mental Health Practitioner (Licensed by NYS Education Department);
7. Certified Rehabilitation Counselor
   (Certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification);

AND
Must have, at a minimum, two (2) years of experience providing adjustment related counseling to individuals with Traumatic Brain Injuries and their families.

Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH waiver management staff and its contractors (RRDCs) at the time of enrollment. For employer-employee the employer is responsible for verifying that that the individuals 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH surveys and/or audits.

Any provider currently providing CIC approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New

employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Counseling (CIC)

Provider Category:
Individual
Provider Type:
Independent Providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Persons self-employed as a Community Integration Counselor must be a/an:

1. Licensed Psychiatrist (licensed by the NYS Education Department);
2. Licensed Psychologist (licensed by the NYS Education Department);
3. Licensed Master Social Worker (LMSW- licensed by the NYS Education Department);
4. Licensed Clinical Social Worker (LCSW- licensed by the NYS Education Department);
5. Individual with a Doctorate degree in Psychology;
6. Licensed Mental Health Practitioner (Licensed by NYS Education Department);
7. Certified Rehabilitation Counselor (Certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification);

AND
Must have, at a minimum, two (2) years of experience providing adjustment related counseling to individuals with Traumatic Brain Injuries and their families.

Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH surveys and/or audits.

Any provider currently providing CIC approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Counseling (CIC)

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 a Community Integration Counselor must be a/an:

1. Licensed Psychiatrist (licensed by the NYS Education Department);
2. Licensed Psychologist (licensed by the NYS Education Department);
3. Licensed Master Social Worker (LMSW- licensed by the NYS Education Department);
4. Licensed Clinical Social Worker (LCSW- licensed by the NYS Education Department);
5. Individual with a Doctorate degree in Psychology;
6. Mental Health Practitioner (Licensed by the NYS Education Department);
7. Certified Rehabilitation Counselor (Certified as a Certified Rehabilitation Counselor (CRC) by the Commssion on Rehabilitation Counselor Certification);

AND
Must have, at a minimum, two (2) years of experience providing adjustment related counseling to individuals with Traumatic Brain Injuries and their families.
Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH waiver management staff and its contractors (RRDC) at the time of 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH surveys and/or audits.

Any provider currently providing CIC approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

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 (HCSS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation

Category 2:	Sub-Category 2:
08 Home-Based Services	08030 personal care

Category 3:	Sub-Category 3:
08 Home-Based Services	08040 companion

Category 4:	Sub-Category 4:

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

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

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

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 service 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. Services are complementary but not duplicative of other services. Home and Community Support Services (HCSS) are utilized when oversight and/or supervision as a discrete service is necessary to maintain the health and welfare of the participant living in the community. Oversight and/or supervision may be needed for safety monitoring to prevent an individual from harmful activities (for example wandering or leaving the stove on unattended). Oversight and/or supervision can be accomplished through cueing, prompting, direction and instruction. If the applicant/participant does not require oversight and/or supervision, HCSS would not be appropriate.

HCSS services are provided under the direction and supervision of a Registered Professional Nurse (RN). The RN supervising the HCSS staff is responsible for developing a plan of care and for the orientation of the HCSS staff about the participant.

All HCSS services are provided by Licensed Home Care Services Agencies (LHCSA) under Article 36 of NYS Public Health Law. All regulations governing the LHCSA are in effect for the provision of this service. LHCSA regulations require nursing visits in the home by a Supervising RN for participants receiving services. The RN assessment, and supervision visit (not to exceed four (4) hours per visit) are billable within this service definition (billed at a rate of up to four (4) hours/units per visit, three (3) times per year). Subsequent visits made by the selected provider's supervising RN for on-the-job training of the HCSS staff are considered administrative costs and, therefore, are not billable and as such incurred by the provider. The RN is responsible for obtaining physician orders to support the need for HCSS as approved in the service plan. Physician's orders must include documentation of the need for oversight and/or supervision as a discrete service based on medical diagnosis.

HCSS services are reimbursed on an hourly basis. HCSS staff must attend team meetings as needed. Each service plan contains an approved number of annual service units a provider is authorized to deliver. The provider cannot exceed the number of approved annual hours of service contained in the service plan.

Regularly scheduled Team Meetings with the participant and service providers are an essential part of assuring the participant's health and welfare. This meeting is instrumental in the development and implementation of the service plan. Failure to attend Team Meetings may jeopardize the ability of the waiver provider to continue to provide waiver services. Participation at the team meeting is to garner information from the participant and informal supports about needed services, change in physical or cognitive status, discussion about individual progress and to make recommended service changes. It is a direct service to the participant.

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. Personal care services are not billed as a separate component of HCSS.

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 NYSDOH. 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:
Services cannot exceed the approved total annual number of hours of services included in the service plan.

The RN assessment, and supervision visit (not to exceed four (4) hours per visit) are billable within this service definition (billed at a rate of up to four (4) hours/units per visit, three (3) times per year),
HCSS staff must attend team meetings as needed. Attendance at the meeting is included in the total number of approved annual hours of service.

On-the-job training is considered administrative costs and is not billable as HCSS.

The selected provider's supervising Registered Professional Nurse will be responsible for supervising HCSS staff. The selected provider's supervising Registered Professional Nurse must conduct an initial home visit on the day and time HCSS staff begins providing services to the participant. The focus of this visit is for the selected provider's supervising Registered Professional Nurse to introduce the staff to the participant, assure services established during the initial assessment continue to be sufficient and, if necessary, complete the environmental portion of the preliminary assessment tool. Any changes indicated will be communicated to the SC and/or MD as appropriate.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 (HCSS)

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):*

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):*

Supervising Registered Nurse must:

(A) Be a Registered Professional Nurse licensed and currently certified to practice as a Registered Professional Nurse in New York State.

(B) Meet physical health requirements set forth by NYSDOH for employees of Licensed Home Care Services Agencies which includes documentation of a yearly physical exam, immunizations, a yearly Mantoux skin test, and a declaration that the person is free from health impairments which pose potential risks to patients or personnel; and

(C) Meet one of the following qualifications:

1. Have at least two years satisfactory recent home health care experience
2. Have 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

If the Registered Professional Nurse does not meet the qualifications set forth in (C1) or (C2), they must act under the supervision of a Registered Professional Nurse who meets the qualifications listed in (A) and (B) of this section and meets one of the qualifications listed in (C) of this section.

HCSS Staff must:

• Be able to follow written and verbal instructions;
• Have the ability and skills necessary to meet the waiver participant's needs that will be addressed through this service;
• Meet physical health requirements set forth by NYSDOH for employees of Licensed Home Care Services Agencies which includes documentation of a yearly physical exam, immunizations, a yearly Mantoux skin test, and a declaration that the person is free from health impairments which pose potential risks to patients or personnel;
• Have a valid certificate to indicate successful completion of a forty (40) hour training program for Level II PCA or PCA Alternate Competency Demonstration equivalency testing that is approved by NYSDOH
• Attend six (6) hours of in-service education per year

All providers of HCSS are required to be a Licensed Home Care Service Agency (LHCSA), HCSS aides must be supervised by a Registered Professional Nurse (licensed by the NYS Education Department) in compliance with Licensed Home Care Service Agency (LHCSA) regulations.

Staff must meet the requirements of Title 10 NYCRR 766.11 Personnel and have completed a criminal history check to the extent required by section 10 NYCRR 400.23; Program staff must act under the direction of an individual who meets the qualifications listed in (A), (B), and one of the qualifications listed in (C) of this section

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH waiver management staff and its contractors (RRDCs) at the time of enrollment. For employer-employee the employer is responsible for verifying that that the individuals 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of

Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH 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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation

Category 2:	Sub-Category 2:
13 Participant Training	13010 participant training

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

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

Service Definition *(Scope):*

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

Independent Living Skills and Training (ILST) services include assessment, training, and supervision of, or assistance to, an individual with issues related to 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 skills to maintain a household.

ILST is provided in the environment and situation that results in the greatest positive outcome for the waiver participant and in an environment where the trained skills are most commonly used. ILST cannot be provided in the Structured Day Program.

The ILST provider utilizes the comprehensive functional assessment of the waiver participant provided through UAS-NY to identify the participant's strengths and weaknesses in performing Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) related to his/her established goals. The UAS-NY is the basis for developing an ILST plan that describes the milestones and interim steps necessary to attain these goals. The UAS-NY also includes a determination of the participant's manner of learning new skills and responses to various interventions. This comprehensive and functional assessment is conducted at least annually from the date of the last assessment and approved by the RRDS in conjunction with the service plan. The UAS-NY is used to develop the detailed plan and service goals for ILST services.

Only in extraordinary situations where the participant benefits specifically from a group setting will this service be approved by the RRDS on other than an individual basis. This arrangement requires prior approval from the RRDC. In such situations, the provider may bill for a pro-rated percentage of the time spent with a participant (total hourly unit(s) divided by the total number of participants in the group). Training time provided to informal supports or waiver or non-waiver service providers must be designated in the service plan in order to be reimbursed and the participant must be present at the time of training.

This service is also used to assist a waiver participant in returning to employment, or expanding the waiver participant's involvement in meaningful activities such as volunteering. The use of this service for these purposes occur only after it is determined that the waiver participant is not eligible for services provided through the New York State Education Adult Career and Continuing Education Services Vocational Rehabilitation (ACCES-VR) or the Commission for the Blind and Visually Handicapped (CBVH); that ACCES-VR and CBVH services have been exhausted; or the activity is not covered by ACCES-VR or CBVH services. ILST is not used as "job coaching", but to provide training in other skills that support vocational opportunities.

This service may continue only when the waiver participant has reasonable and attainable goals. It is used for training purposes and not ongoing long term supports. Justification to provide or continue this service must be clearly stated in a service plan and approved by the RRDS.

ILST is not intended to be a long-term support. Independent Living Skills Training and Development under this waiver is cost-effective and necessary to avoid institutionalization.

ILST providers must participate in Team Meetings and are reimbursed at the hourly rate for their time at the Team Meeting. Meeting time is included in the service plan. Each service plan contains an approved number of annual service units a provider is authorized to deliver. Regularly scheduled Team Meetings with the participant and service providers are an essential part of assuring the participant's health and welfare. This meeting is instrumental in the development and implementation of the service plan. Failure to attend Team Meetings may jeopardize the ability of the waiver provider to continue to provide waiver services. Participation at the team meeting is to garner information from the participant and informal supports about needed services, change in physical or cognitive status, discussion about individual progress and to make recommended service changes. It is a direct service to the participant.

The provider cannot exceed the number of approved annual hours of service contained in the service plan.

All agencies that employ two (2) or more ILSTs must provide supervision by an individual who fully meets the qualifications as an ILST provider. The supervisor is expected to meet any waiver participants prior to approving the training plan developed by an ILST under their supervision, have supervisory meetings with staff on at a monthly basis, and review and sign-off on all training plans. A supervisor may maintain an active caseload of waiver participants.

All ILST services 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.

Any provider currently providing ILST services approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers and staff not meeting the new qualifications will sunset when a staff person terminates employment with the agency they were employed prior to the new criteria.

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

No additional hours are allowed to complete initial and re-assessments. Not to exceed 220 hours annually not to exceed 4 hours per day.

Providers will not be reimbursed for time spent writing ILST plans, reviewing data or writing assessment reports.

The participant must be present at service delivery.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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/an:

1. Licensed Clinical Social Worker (LCSW-licensed by the NYS Education Department);
2. Licensed Master Social Worker (LMSW-licensed by the NYS Education Department);
3. Individual with a Doctorate or Master of Social Work degree;
4. Individual with a Doctorate or Master of Psychology degree;
5. Licensed Physical Therapist (licensed by the NYS Education Department);
6. Registered Professional Nurse (licensed by the NYS Education Department);
7. Certified Teacher of Students with Disabilities (certified by the NYS Education Department);
8. Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification);
9. Licensed Speech Pathologist (licensed by the NYS Education Department); or
10. Licensed Occupational Therapist (licensed by the NYS Education Department);

AND
Must have, at a minimum, one (1) year of experience completing assessments of ADLs/IADLs, developing a comprehensive service plan, teaching individuals with Traumatic Brain Injury to be more functionally independent;

OR

Be an individual with a Bachelor's degree and three (3) years of experience completing assessments of ADLs and IADLs, developing comprehensive service plans and teaching individuals with Traumatic Brain Injury to be more functionally independent;

OR

Be an individual with an Associate's degree and five (5) years of experience completing assessments of ADLs and IADLs, developing a comprehensive service plan, teaching individuals with Traumatic Brain Injury to be more functionally independent.

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.

Any provider currently providing ILST services approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH waiver management staff and its contractors (RRDCs) at the time of enrollment. For employer-employee the employer is responsible for verifying that that the individuals maintain the needed license or certification.

Frequency of Verification:

Upon signed provider agreement: The waiver service provider must report and subsequent change in status to NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH 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 one of the following:

1. Licensed Clinical Social Worker(LCSW-licensed by the NYS Education Department);
2. Licensed Master Social Worker (LMSW-licensed by the NYS Education Department);
3. Individual with a Doctorate or Master of Social Work degree;
4. Individual with a Doctorate or Master of Psychology degree;
5. Licensed Physical Therapist (licensed by the NYS Education Department);

6. Registered Professional Nurse (licensed by the NYS Education Department);
7. Certified Teacher of Students with Disabilities (certified by the NYS Education Department);
8. Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification);
9. Licensed Speech Pathologist (licensed by the NYS Education Department); or
10. Licensed Occupational Therapist (licensed by the NYS Education Department);

Individuals providing ILST services as an independent provider must have, at a minimum one (1) year of experience completing assessments of ADLs/IADLs, developing comprehensive service plans, teaching individuals with Traumatic Brain Injury to be more functionally independent.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH 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 and subsequent change in status to NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH 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:
1. Licensed Clinical Social Worker (LCSW-licensed by the NYS Education Department);
2. Licensed Master Social Worker (LMSW-licensed by the NYS Education Department);
3. Individual with a Doctorate or Master of Social Work degree;
4. Individual with a Doctorate or Master of Psychology degree;
5. Licensed Physical Therapist (licensed by the NYS Education Department);
6. Registered Professional Nurse (licensed by the NYS Education Department);
7. Certified Teacher of Students with Disabilities (certified by the NYS Education Department);
8. Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification);
9. Licensed Speech Pathologist (licensed by the NYS Education Department); or
10. Licensed Occupational Therapist (licensed by the NYS Education Department);

AND
Must have, at a minimum, one (1) year of experience completing assessments of ADLs/IADLs, developing a comprehensive service plan, teaching individuals with Traumatic Brain Injury to be more functionally independent;

OR

Be an individual with a Bachelor's degree and three (3) years of experience completing assessments of ADLs and IADLs, developing comprehensive service plans and teaching individuals with Traumatic Brain Injury to be more functionally independent;

OR

Be an individual with an Associate's degree and five (5) years of experience completing assessments of ADLs and IADLs, developing a comprehensive service plan, teaching individuals with Traumatic Brain Injury to be more functionally independent.

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.

Any provider currently providing ILST services approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

Verification of Provider Qualifications

Entity Responsible for Verification:
NYSDOH 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 and subsequent change in status to NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH 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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support

Category 2: 10 Other Mental Health and Behavioral Services

Sub-Category 2: 10070 psychosocial rehabilitation

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

PBIS services are provided to 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. The primary goal of PBIS services is to decrease the intensity or frequency of targeted behaviors and to teach more socially appropriate behaviors.

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 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 participant must be present whenever services are provided.

A comprehensive assessment of the individual's behavior is completed in the context of his/her medical diagnosis, abilities/disabilities, and the environment which precipitates the behaviors. The number of hours utilized to complete this assessment must be included in the service plan and may not exceed ten (10) hours. This assessment must be consistent with information contained within the UAS-NY assessment.

A detailed behavioral treatment plan including a clear description of successive levels of intervention that must be developed for the individual. All plans must be written in a manner that all natural and paid supports are able to follow the plan and be consistent with the NYSDOH format. An emergency intervention plan is warranted when there is the possibility of the waiver participant becoming a threat to him/herself or others. The plan must be consistent with information presented in the Plan of Protective Oversight (PPO). The plan will be reassessed at least every six (6) months upon review at the Team Meeting, when significant changes in behavior occur or the medical status of the participant changes.

PBIS staff must attend Team Meetings as needed. Each service plan contains an approved number of annual service units a provider is authorized to deliver. The provider cannot exceed the number of approved annual hours of service contained in the service plan. Regularly scheduled Team Meetings with the participant and service providers are an essential part of assuring the participant's health and welfare. This meeting is instrumental in the development and implementation of the service plan. Failure to attend Team Meetings may jeopardize the ability of the waiver provider to continue to provide waiver services. Participation at the team meeting is to garner information from the participant and informal supports about needed services, change in physical or cognitive status, discussion about individual progress and to make recommended service changes. PBIS is a direct service to the participant.

Training of informal supports, waiver and non-waiver service provider staff by the Behavior Specialist or PBIS

Director will be provided to effectively use the basic principles of the behavioral plan. The number of training hours must be designated within the approved service plan in order to be reimbursed. Training hours cannot exceed ten (10) hours per service plan period. PBIS services are provided in the situation where the significant maladaptive behavior occurs. The waiver participant must be present when training occurs.

The provider must complete regular reassessments of the effectiveness of the plan and modify the plan as needed.

The two key positions in PBIS are the Program Director and the Behavioral Specialist. The Director may work as a Behavioral Specialist, or the provider may hire a Behavioral Specialist who must receive ongoing supervision from the Program Director. The Behavioral Specialist is responsible for implementation of the detailed behavioral treatment plan under the direction of the Program Director. Any approved service provider with two (2) or more Behavioral Specialists must have a Program Director.

All agencies that employ two (2) or more Behavior Specialists must provide supervision by an individual who fully meets the qualifications as Program Director. The Program Director is expected to meet any waiver participants prior to approving the behavior plan developed by a Behavior Specialist under their supervision, have supervisory meetings with staff on at a monthly basis, and review and sign-off on all behavior plans. A supervisor may maintain an active caseload of waiver participants.

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.

Any provider currently providing Positive Behavioral Interventions and Support Services approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers and staff not meeting the new qualifications will sunset when a staff person terminates employment with the agency they were employed prior to the new criteria.

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

The number of hours utilized to complete the initial behavioral assessment must be included in the service plan and may not exceed ten (10) hours per service plan period. Hours are not provided to write the plan. The service is limited to 240 hours annually not to exceed 8 hours per day.

Training hours cannot exceed ten (10) hours per service plan period and are contained in the approved number of annual service units a provider is authorized to deliver. The provider cannot exceed the number of approved annual hours of service contained in the service plan.

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: 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):*
Persons employed as a PBIS Program Director must be a:

1. Licensed psychiatrist (licensed by the NYS Education Department);
2. Licensed psychologist (licensed by the NYS Education Department);
3. Doctorate or Master Degree in Psychology;
4. Licensed Clinical Social Worker (LCSW- licensed by the NYS Education Department);
5. Licensed Master Social Worker (LMSW- licensed by the NYS Education Department);
6. Master level Certified Teacher of Students with Disabilities (certified by the NYS Education Department); or
7. Licensed Behavior Analyst (Licensed by the NYS Education Department).

AND
Must have two (2) years of experience developing and implementing intensive behavioral plans.

Persons employed as a Behavioral Specialist must be a/an:

1. Individual with a Bachelor's degree in psychology;
2. Registered Professional Nurse (licensed by the NYS Education Department);
3. Licensed Occupational Therapist (licensed by the NYS Education Department);
4. Licensed Physical Therapist (licensed by the NYS Education Department);
5. Certified Behavior Analyst Assistant (Certified by the NYS Education Department);
6. Individual with a Bachelor's degree and a Certified TBI Specialist;
7. A Certified Rehabilitation Counselor (certified by the Commission on Rehabilitation Counselor Certification);

AND
Must have two years of experience developing and implementing intensive behavioral treatment plans.

All agencies that employ two (2) or more Behavioral Specialists, regardless of credentials, must provide supervision by an individual who meets the criteria for PBIS Program Director.

Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH waiver management staff and its contractors (RRDCs) at the time of enrollment. For employer-employee the employer is responsible for verifying that that the individuals 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH surveys and/or audits.

Any provider currently providing PBIS approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New

employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

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:
Independent PBIS Providers must be a:

1. Licensed psychiatrist (licensed by the NYS Education Department);
2. Licensed psychologist (licensed by the NYS Education Department);
3. Doctorate or Master Degree in Psychology; or
4. Licensed Clinical Social Worker (LCSW- licensed by the NYS Education Department);
5. Licensed Master Social Worker (LMSW- licensed by the NYS Education Department);
6. Certified Master's level Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department);

AND
Must have two years of experience developing and implementing intensive behavioral plans.

Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH waiver management staff and its contractors (RRDCs) for provider type at the time of 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 NYSDOH waiver management staff and/or its contractors (RRDC). NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify qualifications through NYSDOH surveys and/or audits.

Any provider currently providing PBIS approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

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):*
Persons employed as a PBIS Program Director must be a:

1. Licensed psychiatrist (licensed by the NYS Education Department);
2. Licensed psychologist (licensed by the NYS Education Department);
3. Doctorate or Master Degree in Psychology; or
4. Licensed Clinical Social Worker (LCSW- licensed by the NYS Education Department);
5. Licensed Master Social Worker (LMSW- licensed by the NYS Education Department);
6. Certified Master's level Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department);

AND
Must have two years of experience developing and implementing intensive behavioral plans.

Persons employed as a Behavioral Specialist must be a/an:

1. Individual with a Bachelor's degree in psychology;
2. Registered Professional Nurse (licensed by the NYS Education Department);
3. Licensed Occupational Therapist (licensed by the NYS Education Department);
4. Licensed Physical Therapist (licensed by the NYS Education Department);
5. Individual with a Bachelor's degree and certified in Applied Behavioral Analysis (ABA);
6. Individual with a Bachelor's degree and a Certified TBI Specialist;
7. A Certified Rehabilitation Counselor (certified by the Commission on Rehabilitation Counselor Certification);

AND
Must have two years of experience developing and implementing intensive behavioral plans.

All agencies that employ two (2) or more Behavioral Specialists, regardless of credentials, must provide supervision by an individual who meets the criteria for PBIS Program Director.

Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH waiver management staff and its contractors (RRDCs) at the time of enrollment. For employer-employee the employer is responsible for verifying that that the individuals 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH surveys and/or audits.

Any provider currently providing PBIS approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

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 (SDP)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation

Category 2:	Sub-Category 2:
04 Day Services	04060 adult day services (social model)

Category 3:	Sub-Category 3:
04 Day Services	04070 community integration

Category 4:	Sub-Category 4:

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

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

Service Definition *(Scope):*

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

Structured Day Program (SDP) services are individually designed services provided to facilitate acquisition, retention, or improvement in self-help, socialization, and adaptive skills and takes place in a non-residential setting separate from the participant's private residence or other living arrangement.

Services may include assessment, training, supervision, or assistance to an individual with issues related to self-care, attention deficit, memory loss, task completion, communication skills, interpersonal skills, problem-solving skills, socialization, sensory/motor skills, mobility, community, and transportation skills. Unlike ILST services, Structured Day Program services are provided in a socialized group setting outside of the home. This service may continue only when the waiver participant has reasonable and attainable goals. It is used for training purposes and not ongoing long term supports. Justification to provide or continue this service must be clearly stated in a service plan and approved by the RRDS.

Structured Day Program services may be used to reinforce aspects of other HCBS/TBI waiver and Medicaid State Plan services. This is addressed due to the difficulty many individuals with Traumatic Brain Injury have transferring or generalizing skills learned in one setting to other settings and the need for consistent reinforcement of skills. This service is intended to provide an opportunity for the 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 in a variety of settings and with very different goals. However, each day program must provide a site where participants can meet when arriving and departing from the day program. There must also be a site available where participants can receive services if they choose not to go out into the community. Structured Day Program Services cannot be provided in the participant's home. 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 is located in a building that meets all provisions of the NYS Uniform Fire Prevention and Building Codes. In addition, access to the program adheres to requirements of the Americans with Disabilities Act. The RRDS and/or NYSDOH staff determine the appropriateness of the physical space for the TBI Waiver participants by completing a site visit.

In extreme circumstances and with the approval of NYSDOH, HCSS staff may attend Structured Day Program services with participants in order to assist with personal care activities while out of the home. The need for this assistance is clearly defined in the participant's service plan to ensure when services are considered supportive and not duplicative.

Structured Day Program staff must attend team meetings as needed. Team Meetings are participant centered and not staff meetings or staff training. Regularly scheduled Team Meetings with the participant, family, informal supports and service providers are an essential part of assuring the participant's health and welfare. This meeting is instrumental in the development and implementation of the service plan. Failure to attend Team Meetings may jeopardize the ability of the waiver provider to continue to provide waiver services. Participation at the team meeting is to garner information from the participant and informal supports about needed services, change in physical or cognitive status, discussion about individual progress and to make recommended service changes. It is a direct service to the participant and scheduled at least every six (6) months or when the needs or the condition of the participant warrant review and potential amendment to his/her service plan.

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 services are not required to be provided under the direct order of a physician. This service is reimbursed on an hourly basis, not to exceed ten (10) hours per day. Participation in Team Meetings is reimbursed at the hourly rate and included in the total number of approved annual hours of service.

Any provider currently providing Structured Day Program Services approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers and staff not meeting the new qualifications will sunset when a staff person terminates employment with the agency they were employed prior to the new criteria. Each service plan contains an approved number of annual service units a provider is authorized to deliver. The provider cannot exceed the number of approved annual hours of service contained in the service plan.

The Structured Day Program must be documented in the Service Plan and provided by agencies approved as a provider of waiver services by NYSDOH. 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:
This service is reimbursed on an hourly basis, not to exceed ten (10) hours per day.

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 (SDP)

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 a Structured Day Program Director must be a/an:

1. Licensed Master Social Worker (LMSW- licensed by the NYS Education Department);
2. Licensed Clinical Social Worker (LCSW- licensed by the NYS Education Department);
3. Individual with a Doctorate or Master of Social Work degree;
4. Individual with a Doctorate or Master of Psychology degree;
5. Licensed Physical Therapist (licensed by the NYS Education Department);
6. Registered Professional Nurse (licensed by the NYS Education Department);
7. Certified Teacher of Students with Disabilities (certified NYS Education Department);
8. Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification);
9. Licensed Speech Language Pathologist (licensed by the NYS Education Department);
10. Licensed Occupational Therapist (licensed by the NYS Education Department);

AND
Must have one year of experience developing and implementing day habilitation plans; providing vocational education services; providing residential habilitation services; or providing job coaching or supportive employment services.

OR

Individual with a Bachelor's degree and two (2) years of experience developing and implementing day habilitation plans; providing vocational education services; providing residential habilitation services; or providing job coaching or supportive employment services.

The SDP must be available to provide hands-on assistance to members, and therefore, must have at least 1 employee with previous training as a PCA or CNA available to members at all times. In addition to a required Program Director and staff with PCA/CNA training, a SDP may employ additional program staff. Persons employed as 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:
NYSDOH waiver management staff and its contractors (RRDCs) at the time of enrollment. For employer-employee the employer is responsible for verifying that that the individuals 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee,

the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH surveys and/or audits.

Any provider currently providing Structured Day Program Services approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Structured Day Program Services (SDP)

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 a Structured Day Program Director bust be a/an:

1. Licensed Master Social Worker (LMSW- licensed by the NYS Education Department);
2. Licensed Clinical Social Worker (LCSW- licensed by the NYS Education Department);
3. Individual with a Doctorate or Master of Social Work degree;
4. Individual with a Doctorate or Master of Psychology degree;
5. Licensed Physical Therapist (licensed by the NYS Education Department);
6. Registered Professional Nurse (licensed by the NYS Education Department);
7. Certified Teacher of Students with Disabilities (certified by the NYS Education Department);
8. Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification);
9. Licensed Speech Language Pathologist (licensed by the NYS Education Department);
10. Licensed Occupational Therapist (licensed by the NYS Education Department);

AND
Must have one year of experience developing and implementing day habilitation plans; providing vocational education services; providing residential habilitation services; or providing job coaching or supportive employment services.

OR

Individual with a Bachelor's degree and two (2) years of experience developing and implementing day habilitation plans; providing vocational education services; providing residential habilitation services; or providing job coaching or supportive employment services.

The SDP must be available to provide hands-on assistance to members, and therefore, must have at least

1 employee with previous training as a PCA or CNA available to members at all times. In addition to a required Program Director and staff with PCA/CNA training, a SDP may employ additional program staff. Persons employed as 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:
NYSDOH waiver management staff and its contractors (RRDCs) at the time of enrollment. For employer-employee the employer is responsible for verifying that that the individuals 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH surveys and/or audits.

Any provider currently providing Strucuted Day Program Services approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling

Category 2:	Sub-Category 2:
10 Other Mental Health and Behavioral Services	10070 psychosocial rehabilitation

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

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

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

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

The program must have a fully developed plan which details how it will work with existing community support programs, such as Alcoholics Anonymous and secular organizations for sobriety that provide ongoing support to individuals with substance abuse problems.

The UAS-NY assessment must be reviewed to confirm the current status of the individual and the need for counseling services. Counseling goals must be developed that are reflective of the assessment findings. This analysis is included in the participant file and the goals included in the service plan and reassessed annually. Goals must be reasonable and attainable.

Substance Abuse Program services are provided in a non-institutional setting and 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 participant's substance abuse history and cognitive abilities; implementation of the plan; on-going education and training of the participant, family members, informal supports and all other service providers; individualized relapse strategies; periodic reassessment of the plan; and ongoing support. The treatment plan addresses individual interventions and must reflect the use of curriculum and materials adopted from a traditional substance abuse program to meet the needs of individuals with Traumatic Brain Injury. The participant must be present at service delivery.

The Substance Abuse 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 waiver participants' safety, 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 adheres to requirements of the Americans with Disabilities Act. The RRDS and/or NYSDOH staff determine the appropriateness of the physical space for the TBI Waiver participants by completing a site visit.

This service does not duplicate other services available through the New York Medicaid State Plan. Therefore, once the counseling is no longer specific to substance abuse issues as related to TBI and becomes general therapeutic counseling the service terminates. Upon initiation of the service, an initial assessment is completed and includes specific counseling goals. The initial service assessment does not exceed three (3) hours within the service plan period. This report is included in the participant file and the goals included in the service plan and reassessed annually.

This service is reimbursed on an hourly basis and for direct contact only, not to exceed three (3) hours per day. Substance Abuse Program staff must attend team meetings as needed. Team Meetings are participant centered and not staff meetings or staff training.

Regularly scheduled Team Meetings with the participant, family, informal supports and service providers are an essential part of assuring the participant's health and welfare. This meeting is instrumental in the development and implementation of the service plan. Failure to attend Team Meetings may jeopardize the ability of the waiver provider to continue to provide waiver services. Participation at the team meeting is to garner information from the participant and informal supports about needed services, change in physical or cognitive status, discussion about individual progress and to make recommended service changes. It is a direct service to the participant and scheduled at least every six months or when the needs or the condition of the participant warrant review and potentially amendment to his/her service plan.

Each service plan contains an approved number of annual service units a provider is authorized to deliver. The provider cannot exceed the number of approved annual hours of service contained in the service plan.

Participation in Team Meetings is reimbursed at the hourly rate and included in the total number of approved annual hours of service.

This program differs from State plan service in that these services integrate non-residential services with participant specific interventions. The provision of Substance Abuse Programs Services under this waiver is cost-effective and necessary to avoid institutionalization.

All agencies that employ two (2) or more Substance Abuse Counselors must provide supervision by an individual who fully meets the qualifications as Program Director. The Program Director is expected to meet any waiver participants on a yearly basis, prior to the approval of their service plan. The Program Director has supervisory meetings with staff on a monthly basis, and provides case consultation. A Program Director may maintain an active caseload of waiver participants, however the size of the caseload should be adjusted in order to afford sufficient time for supervision of staff and provide enough time to offer sufficient support to individuals served.

All Substance Abuse Programs Services are documented in the Service Plan and provided by agencies approved as providers of this waiver service by the New York State 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.

Any provider currently providing Substance Abuse Services prior to the effective date of this application is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers and staff not meeting the new qualifications will sunset when a staff person terminates employment with the agency they were employed prior to the new criteria.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is reimbursed on an hourly basis and for direct contact only, not to exceed three (3) hours per day. No more than three hours will be utilized to complete the initial service assessment.

This service does not duplicate other services available through the New York Medicaid State Plan. Therefore, once the counseling is no longer specific to substance abuse as related to TBI and becomes general therapeutic counseling the service terminates.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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: 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):*

Persons employed as a Substance Abuse Program Director must be a health care professional with an advanced Human Services degree:

1. Licensed Master Social Worker (LMSW- licensed by the NYS Education Department);
2. Licensed Clinical Social Worker (LCSW- licensed by the NYS Education Department);
3. Doctorate or Master of Social Work;
4. Doctorate or Master of Psychology;
5. Registered Professional Nurse (licensed by the NYS Education Department pursuant to NYS Education Law);
6. Certified Teacher of Students with Disabilities (certified by the NYS Education Department);
7. Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification);
8. Licensed Occupational Therapist (licensed by the NYS Education Department);

AND

Must be a Credentialed Alcoholism and Substance Abuse Counselor (CASAC- Certified by the New York State Office of Alcoholism and Substance Abuse Services);

AND

Must have at least one (1) year experience providing services to individuals with Traumatic Brain Injury or providing services to individuals with a history of substance abuse.

Persons employed as Substance Abuse Counselors must be an:

Individual with a Bachelor's degree in psychology, social work, special education, or rehabilitation counseling;

AND

Must have two (2) years of experience providing services to individuals with Traumatic Brain Injury or providing services to individuals with a history of substance abuse;

AND

Must be Credentialed Alcoholism and Substance Abuse Counselors (CASAC- Certified by the New York State Office of Alcoholism and Substance Abuse Services).

All agencies that employ two (2) or more Substance Abuse Counselors must be supervised by a Substance Abuse Program Director.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH waiver management staff and its contractors (RRDCs) at the time of enrollment. For employer-employee the employer is responsible for verifying that the individuals 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH surveys and/or audits.

Any provider currently providing Substance Abuse Services approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

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 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 a Substance Abuse Program Director must be a health care professional with an advanced Human Services degree:

1. Licensed Master Social Worker (LMSW- licensed by the NYS Education Department);
2. Licensed Clinical Social Worker (LCSW- licensed by the NYS Education Department);
3. Doctorate or Master of Social Work;
4. Doctorate or Master of Psychology;
5. Registered Professional Nurse (licensed by the NYS Education Department pursuant to NYS Education Law);
6. Certified Teacher of Students with Disabilities (certified by the NYS Education Department);
7. Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification);
8. Licensed Occupational Therapist (licensed by the NYS Education Department);

AND
Must also be a Credentialed Alcoholism and Substance Abuse Counselor (CASAC- Certified by the New York State Office of Alcoholism and Substance Abuse Services);
AND
Must have at least one (1) year experience providing services to individuals with traumatic brain injury or providing services to individuals with a history of substance abuse.

Persons employed as Substance Abuse Counselors must be an:

Individual with a Bachelor's degree in psychology, social work, special education, or rehabilitation counseling and two (2) years of experience providing services to individuals with traumatic brain injury or providing services to individuals with a history of substance abuse.

AND
Must be Credentialed Alcoholism and Substance Abuse Counselors (CASAC- Certified by the New York State Office of Alcoholism and Substance Abuse Services).

All agencies that employ two (2) or more Substance Abuse Counselors must be supervised by a Substance Abuse Program Director.
Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH waiver management staff and its contractors (RRDCs) at the time of enrollment. For employer-employee the employer is responsible for verifying that that the individuals 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 NYSDOH waiver management staff and/or its contractors (RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff verify employee qualifications through NYSDOH surveys and/or audits.

Any provider currently providing Substance Abuse Services approved pursuant to the qualifications in the waiver prior to the most recent approval is approved to provide services under the new application. New employees/providers are required to meet the new qualifications. The grandfathering of current providers sunsets when the staff person terminates employment with the current employer.

Appendix C: Participant Services

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

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

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

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):

Chapter 769 of the Laws of 2005, as amended by Chapters 331 and 673 of the Laws of 2006, imposed the requirement for review of the criminal history record of certain prospective employees of residential health care facilities licensed under Article 28 of the Public Health Law and certified home health agencies, licensed home care services agencies or long term home health care programs certified, licensed, or authorized under Article 36 of the Public Health Law who are hired or used on or after September 1, 2006 and who will provide direct care or supervision to patients, residents or clients of such providers.

The only providers that can and must request criminal history checks on covered employees through the Department of Health are nursing homes licensed under Public Health Law (PHL) Article 28, home care services agencies licensed under Public Health Law Article 36 and any adult home, enriched housing program or residence for adults licensed under Article 7 of the Social Services Law (SSL). Article 36 home care services agencies which include licensed home care services agencies, and certified home health agencies must request criminal history record checks on covered employees. Each provider shall assure that criminal history information is requested, received, reviewed, and acted upon in a timely manner.

The NYSDOH Criminal History Record Check (CHRC) Unit reviews any unlicensed individual employed by or used by a subject employer (above) who provides direct care or supervision to a patient or resident or who has access to a patient or resident, their living quarters or their property is subject to Criminal History Record Check (CHRC). This includes aides to professionals licensed under Title 8 of the NYS Education Law (dietary aides, rehabilitation and other therapy aides, etc.), certified nursing assistants (CNAs), home health aides (HHAs), personal care aides (PCAs), home attendants, hairdressers (if paid by provider), maintenance workers, etc. Also subject to CHRC are LPNs and RNs working out of title. Each employer submits the background/fingerprint request to the NYSDOH CHRC Unit through their own agency account established in the Health Commerce System (HCS.)Each provider must designate at least two staff with access to the system.

Providers are required to have written policies and procedures for CHRC. These policies and procedures should include, but are not limited to: Determining who is subject to a background check according to regulations. These protocols are reviewed upon survey by the Home Care Surveillance Unit. In addition to reviewing the protocols, the Surveillance Unit verifies employee rosters, the agency's process for requesting and obtaining Livescan fingerprinting within 15 calendar days of date of hire; supervision of staff pending final determination; the process for reporting terminations and separations, retention, confidentiality and separation of personnel records.

To the extent permitted by law, a provider shall request from a prospective employee a sworn statement disclosing any prior finding of patient or resident abuse, or a criminal conviction in this State or any other jurisdiction. Providers shall evaluate such statements in all hiring decisions, including any temporary employment.

The provider shall inform the potential employee in writing that:

(1) the provider is required to request a check of his or her criminal history information and review the results of such criminal history record check; and
(2) the individual has the right to obtain, review and seek correction of his or her criminal history information pursuant to rules and regulations established by the Division and the FBI.

The provider shall obtain the signed, informed consent of the individual in the form and format specified by the Department which indicates that the individual has:

• been informed of the right and procedures necessary to obtain, review and seek correction of his or her criminal history information;
• been informed of the reason for the request for his or her criminal history information;
• consented to the request for a criminal history record check; and
• supplied on the form a current mailing or home address.

An individual may withdraw his or her application for employment, without prejudice, at any time before employment is offered or declined, regardless of whether the subject individual or provider has reviewed the summary of the subject individual's criminal history information.

The provider must submit an electronic submission of the CHRC as soon as possible. The background check must be submitted immediately, or as soon as possible, once the employer reasonably expects to hire, employ or use the individual. Providers may temporarily approve the prospective employee (temporary employee) pending completion of a CHRC and employment eligibility determination. If the individual has been previously reviewed by the CHRC Unit an expedited review is conducted using available information. New fingerprinting is not required. If the individual has not been previously reviewed by CHRC, fingerprinting is required and the provider will receive an Appointment Letter in the HCS document viewer. Providers check the viewer daily and take appropriate action as directed in the correspondence. Appointments for fingerprinting may be made either online or via telephone and should be scheduled at a time and location convenient for the prospective employee. A State contractor provides all fingerprinting service to CHRC under a contract with the Division of Criminal Justice Services (DCJS). The fingerprint vendor provides these services at over 90 locations statewide.

A provider may temporarily approve a prospective employee while the results of the criminal history record check are pending. The provider shall implement the supervision requirements applicable to the provider, during the period of temporary employment. A temporary employee who has not received approval for hire must be supervised until the CHRC determination has been received. Such temporary employees must be directly observed and evaluated and the supervision must be documented by a member of the provider's staff weekly. The provider is required to produce written documentation of supervision. This documentation should be completed by the individual who has performed the supervision. Documentation must include how the supervision was performed, those involved in the supervision and the dates the supervision occurred. This documentation is reviewed upon survey.

The provider is responsible for paying the fingerprinting fee. By law, costs associated with fingerprinting cannot be charged to the prospective employee. The results of the CHRC are posted to the provider's account in HCS via a weekly acknowledgement Report, monthly reports and upon survey.

The provider:

• identifies the name of each person for whom the provider requests a criminal record check, and attests that each such person is a prospective employee of the provider,
• identifies the specific duties of the subject individual which qualify the provider to request a check
• attests that the provider, its agents, and employees are aware of and will abide by the confidentiality requirements and all other provisions of Public Health Law Article 28-E and Executive Law section 845-b
• shall require that the prospective employee present two forms of identification in obtaining fingerprints. Examples of such identification are a valid driver's license or a Department of Motor Vehicle ID, a current passport, valid military identification or valid school identification. At least one of the two forms of identification shall have a photograph of the prospective employee.

Where the criminal history information of a prospective employee reveals a felony conviction at any time for a sex offense, a felony conviction within the past ten years involving violence, or a conviction for endangering the welfare of an incompetent or physically disabled person pursuant to section 260.25 of the Penal Law, or where the criminal history information concerning such prospective employee reveals a conviction at anytime of any class A felony, a conviction within the past ten years of any class B or C felony, any class D or E felony defined in articles 120, 130, 155, 160, 178 or 220 of the Penal Law or any crime defined in sections 260.32 or 260.34 of the Penal Law or any comparable offense in any other jurisdiction, the Department shall propose disapproval of such person's eligibility for employment unless the Department determines, in its discretion, that the prospective employee's employment will not in any way jeopardize the health, safety or welfare of patients, residents or clients of the provider. In cases where the Department determines that the prospective employee's employment will not in any way jeopardize the health, safety or welfare of patients, residents or clients of the provider and therefore neither issues a disapproval of eligibility for employment nor directs the provider to issue a disapproval, the provider may act on the application in its own discretion.

Only an authorized person(s) or his or her designee who shall be employed by the provider and the individual shall have access to criminal history information received by a provider

Each authorized person(s) and any other party to whom such criminal history information is disclosed shall keep criminal history information strictly confidential.

Each provider shall establish, maintain, and keep current, all records. Records shall be maintained in a manner that ensures the security of the information contained therein, but which also assures the Department of immediate and unrestricted access to such information upon its request, for the purpose of monitoring compliance. At the time of surveillance, NYSDOH surveyors from the Bureau of Homecare Licensure and Certification review a sample, as determined by the bureau, of recently hired employees which includes employees/applicants with a negative determination report. If a provider is found to be not in compliance with the regulations, a statement of deficiency (ies) is issued for which the provider must provide a plan of correction. Licensed Home Care Agencies and Certified Home Health Agencies are surveyed, at a minimum, once every three (3) years.

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).**

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

◉ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

NYSDOH waiver management staff and/or its contractors (RRDCs) conduct regional meetings, open forums, and information sessions in order to educate the community at large about the TBI waiver. The RRDS is directed by NYSDOH to facilitate meetings with potential providers to inform them of the opportunities to provide waiver services.

The approved TBI waiver application is posted on the NYSDOH website, as well as the program manual, providing ready access to the necessary information for all potential providers. Providers may seek to enroll at any time during the course of the approved waiver period.

The RRDC contract work plans include goals for community outreach and provider enrollment. Throughout the contract year, the RRDC develops and implements an outreach plan to identify available providers for each of the waiver services in the region and to ensure participant choice in each county within the region.

Throughout the contract year, the RRDC recruits and submits application packets to NYSDOH for providers for each of the waiver services to ensure participant choice and sufficient provider capacity.

Throughout the contract year, the RRDC conducts targeted recruitment for areas that are assessed as “difficult to serve” geographic locations.

Throughout the contract year, the RRDC provides technical assistance and support to new and approved service providers on TBI waiver policies and procedures.

At the end of each contract quarter, the RRDC develops and implements alternatives to experienced barriers to maximize provider enrollment and training. On an ongoing basis, the RRDCs gather information from waiver service providers on barriers experienced related to enrollment and training. The RRDC adjusts its recruitment practices based on this information.

The RRDC facilitates the provider application process by providing tools, technical assistance, help with developing policies and procedures, and training.

Prior to approval of a waiver service provider, the RRDC receives a letter of intent from the provider listing the services, counties, and the region in which it is seeking to provide services. The letter includes a brief description of the agency’s history of providing services to individuals with TBI or other disabilities.

Waiver providers are responsible to assure their staff meet all qualification requirements established in the waiver. Prior to arranging an interview with the potential provider, the RRDS reviews the Provider Enrollment Application Packet and determines preliminary eligibility. This includes reviewing and verifying the provider meets the licensure, certification,

and staff qualifications to support the services requested for approval.

The RRDS conducts an interview with each potential waiver service provider, which includes evaluation of employee resumes to ensure employees meet the required qualifications.

All RRDC contractors utilize the same forms and practices for provider enrollment. The RRDS is responsible for reviewing the provider's application and the request to provide specific services based on: personnel qualifications as established in the TBI Program Manual and waiver application; the capacity of the agency to develop and maintain high quality services; and the provider's willingness to adhere to the philosophy and policies of the waiver. Upon review of all supporting documentation, the RRDS determines the provider enrollment packet is complete and refers the application to NYSDOH for final review and approval.

Any willing and qualified provider may, at any time, seek approval to add services. If a provider seeks approval for additional services, the RRDS interviews the provider and reviews the qualifications of staff providing the additional services.

NYSDOH waiver management staff verifies the accuracy of the Federal Employee Identification Number (FEIN) and incorporation status, provider agreement, eMedNY application, and ensures the paperwork is accurately executed. NYSDOH waiver management staff also review the employee qualifications to verify the provider attestation of employee qualifications. Attached to the signed Employee Verification of Qualifications form is the individual's resume and license/diploma/certification, as required. Upon review of the complete application and supporting documents, NYSDOH waiver staff approve the application.

The Office of Health Insurance Programs (OHIP) assigns a provider identification number and uploads the information into the provider's eMedNY file. This number is dedicated solely to TBI service providers and assures that only enrolled waiver providers are billing for services. Each waiver service is assigned a unique rate code. This allows the provider to bill electronically through the system via eMedNY. TBI waiver management staff are advised of the provider ID number and then provides OHIP with the approved rate codes.

Waiver services will not be provided to individuals living in enriched housing, residential health care facilities and adult care facilities.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of all non-licensed/non-certified providers that continue to meet TBI waiver qualifications upon survey (percentage = numerator: number of

non/licensed/non-certified providers that meet TBI waiver provider qualifications upon survey/ denominator: total number of approved TBI providers surveyed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report summaries

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: RRDC, OMIG, Surveillance	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: RRDC visit providers quarterly Waiver staff cannot dictate survey sample for OMIG
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of all non-licensed/non-certified providers that meet TBI waiver qualifications upon application (percentage = numerator: number of non/licensed/non-certified providers that meet TBI waiver provider qualifications upon application/denominator: total number of new provider applicants)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Documentation submitted to the RRDC and NYSDOH by the provider

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
The number and percentage of new waiver provider applicants that complete HCBS Provider Agreements (percentage = numerator: number of waiver provider applicants with completed provider agreements/denominator: total number of waiver provider applicants)

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

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Upon application and waiver renewal	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: RRDC	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Upon application and waiver renewal

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of all approved providers meeting training requirements by region (percentage = numerator: number of approved providers attending eight training sessions per year per region/ denominator: total number of approved providers per region)

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:
Quarterly reports from RRDCs, Surveillance reports

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

☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: RRDC	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. NYSDOH waiver staff obtain reasonable assurances that the applying agency is capable of delivering services in accordance with the operational standards and intent of this waiver. NYSDOH waiver staff contact other New York State agencies to gather information about the current status and background of the potential provider, including any past experience in providing HCBS waiver services. NYSDOH waiver management staff review information about providers through Automated Survey Processing Environment (ASPEN), the Attorney General's office, OMIG, OIG and web searches prior to approving providers.

NYSDOH monitors non-licensed/non-certified providers to assure adherence to waiver requirements through the RRDC and the NYSDOH Office of Primary Care and Health Systems Management (OPCHSM). NYSDOH waiver management staff review information about providers through Automated Survey Processing Environment (ASPEN), the Attorney General's office, OMIG, OIG and web searches. If there are questions about the provider's ability to meet the standards the following action may be taken: request for a plan of corrective action, referral made to OMIG or request an additional survey of the provider.

Any certified home health agency (CHHA)or licensed home care services agency (LHCSA), licensed or authorized under Article 36 of the Public Health law to provide services to patients of clients, shall request a criminal history record check for each prospective employee to provide direct care or supervision to patients, or clients. Due to this standard, the only waiver service requiring background checks is HCSS. The checks are required as a standard of licensure and at the time of survey.

RRDCs maintain attendance sheets of all provider trainings. These documents are reviewed by NYSDOH during site visits. RRDCs include provider training data in the RRDC Quarterly report.

Waiver providers are responsible for maintaining ongoing training for their staff to assure that waiver compliance standards are met. This information is reviewed upon survey.

RRDC staff provides NYSDOH with an annual schedule of all provider meetings. A master schedule is maintained by NYSDOH. Provider meetings are utilized as a mechanism for program updates and include at least one training topic per meeting. Samples of training materials and agenda are provided to NYSDOH.

If, at any time, a provider is unable to maintain qualified staff for a service, it is no longer able to provide that service. The waiver provider must report any changes in status to the appropriate RRDC.

Providers who have not provided waiver services in two or more years and wish to resume providing services must contact the appropriate RRDC to reapply as a waiver provider with current and appropriate documentation.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
NYSDOH waiver management staff provide ongoing technical assistance to RRDC staff and providers about the qualifications and criteria necessary to be an approved TBI waiver provider.

NYSDOH may terminate the approval of an entity to provide any or all waiver services with at least sixty (60) days written notice.

Provider enrollment practices are reviewed on an on-going basis at Quarterly RRDC meetings.

A provider database system is maintained by NYSDOH to track information throughout the provider enrollment process as well as maintain critical information that facilitates the monitoring of providers and the survey process.

Information received via TBI complaint lines is maintained and used as a source to identify on-going issues or trends in service provision related to specific providers.

NYSDOH and/or RRDCs review training materials used by a waiver provider to train their staff and make recommendations for changes or improvements.

NYSDOH and/or RRDCs attend waiver service provider trainings as necessary.

NYSDOH waiver management staff designate time in each RRDC quarterly meeting to provide training by subject matter experts on a variety of waiver implementation issues.

Documentation of remediation activities is accomplished by the following measures: correspondence among NYSDOH waiver staff, the RRDC, participants and their legal guardians, and/or service providers; amended service plans; findings from retrospective record reviews and reports of follow-up meetings with participants; and the results of NYSDOH site visits.

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

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

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

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

Individuals receiving waiver services reside in their own home. Residential settings of four or more unrelated individuals are excluded. Waiver participants at the time of the approval of the waiver application residing in a setting of four or more unrelated individuals will be grandfathered in until such time as the individual moves or the state transition plan is fully implemented. The services and supports available through the waiver and other sources must be sufficient to maintain the individual's health and welfare in the community. The living environment must be fully integrated into the broader community and selected by the participant. Waiver services provided outside the home should not be in a consolidated/congregate location or on the grounds or immediately adjacent to a public institution. New York State continues to move forward with its statewide transition plan to be fully compliant with the federal rule.

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)**

- [x] **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 TBI waiver makes every effort to promote the right of waiver applicants and participants to choose participation in the TBI waiver, identify needed services, and select their service providers. Agencies that provide Service Coordination (SC) must adhere to conflict of interest (COI) requirements established by the Department. Compliance with these practices promotes the independence of the Service Coordinator and ensures participant choice. The Service Coordinator is responsible for providing unbiased and comprehensive information to the waiver participant about available services and service providers. A Service Coordinator may not “steer” business and may not recommend or indicate a preference for a service provider.

Upon approval of this application, NYSDOH will issue written guidance on COI requirements and the subsequent programmatic changes. Providers will be afforded the opportunity to present how to effectively implement compliance with the new service criteria through routine Regional Provider meetings.

NYSDOH will train all RRDCs in the compliance criteria for providers and the oversight responsibilities of the RRDC. Additionally, due to proposed clarification associated with rate methodology, the RRDCs and providers will be provided instruction related to Certified Cost Reporting (CCR) and billing practices.

Any case directly impacted by the new COI criteria that requires re-assignment will be identified for transition as established in the corrective action plan (CAP).

The Service Coordinator (SC) assists the prospective participant in securing waiver eligibility, coordinates service provision and monitors the delivery of all services in the service plan. Services may include Medicaid State Plan services, non-Medicaid federal, state and locally funded services, as well as educational, vocational, social, and medical services. Additionally, the Service Coordinator must initiate and oversee the assessment and reassessment of the participant’s level of care and on-going review of the service plan.

The following safeguards ensure that the service plan development is conducted in the best interests of the waiver participant and ensures choice:

1. The RRDS explains to the applicant that he/she has a choice of service providers, identifies services and

service limits and encourages the potential participant to interview SCs/providers to make an informed choice.

2. The potential participant selects a Service Coordination Agency from the list of approved providers. The SC is responsible for providing the participant with information regarding their choice of all waiver service providers.

3. Throughout the Initial and Revised Service plan processes, the SC is responsible for providing to the participant information about the full range of waiver services available from all service providers.

4. The waiver applicant signs the Provider Selection form. By signing the form, the waiver applicant is affirming that he/she was given a choice of approved waiver providers.

5. The applicant's/participant's signature is required on service plans, and any addendum to the service plan. This signature indicates that the participant agrees with the information that is included in the service plan, the services requested and the chosen providers of the services. Services may not be provided without this expressed consent.

6. On an annual basis, the participant reviews and signs the Participant Rights and Responsibilities Form, which describes the right to choose and change waiver service providers as requested.

7. The participant has the right to change waiver service providers at any time during the approved service plan period. The RRDS will provide information to the participant about Service Coordination providers and assist the participant with completing the Change of Provider Form.

8. The RRDS reviews each service plan to assure it meets the assessed needs of the participant and reflects waiver participant choice.

9. Complaint lines are established for participants to present any concerns or issues they may have regarding their services or providers.

10. A statistically reliable sample, determined by the Raosoft software, of waiver participants receive an annual participant satisfaction survey using a statewide survey tool to obtain feedback about the services and supports that they receive through the waiver.

11. Each RRDC conducts an annual self-audit/retrospective review of records of a statistically significant sample. A standardized form for the audit is distributed by NYSDOH and utilized on a statewide basis. Team meeting summaries and participant signatures are reviewed and confirmed to ensure participation in the development and approval of services.

NYSDOH has the responsibility to assure informed choice of providers for all participants. In the event of coercion by providers, the provider will be subject to corrective actions.

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, available services, application and service plan development process, role of the Service Coordinator, a list of available Service Coordination agencies and the Fair Hearing process. Service plans address many aspects of the participant's life including safety, independent living skills and medical and cognitive needs. As a result, family members, friends and informal supports are encouraged to provide input into the participant's service goals. The waiver participant may include any person of his/her choosing to assist in the development of the Service Plan.

The participant may also be advised of advocates available through local Independent Living Centers and advocacy groups, should they require assistance with resources beyond the scope of the waiver.

It is the responsibility of the SC to invite representatives of the participant's choice to be involved in service plan

development. The SC is required to include the participant, their advocate, and any other family or friends selected by the participant. Additionally, at the mid-year Team Meeting, a representative from each of participant's service providers is required to attend the meeting. It is ultimately the decision of the participant and his/her advocate to decide who will participate in the service plan development process.

The Waiver Participant's Rights and Responsibilities form must be signed and dated by the applicant. The original document is included in the Application Packet. A copy is given to the participant to be maintained in an accessible location in the participant's home. The document is reviewed with the participant on an annual basis. The document advises that as a waiver participant they have the right to:
• Be provided with an explanation of all services available in the Traumatic Brain Injury (TBI) waiver and other health and community resources that may benefit the individual;
• Have assistance reviewing and understanding waiver material;
• Have the opportunity to participate in the development, review, and approval of all Service Plans, including any changes to the Service Plan;
• Determine who the individual wishes to include in the service planning process;
• Freely choose his/her service provider.

The Service Coordinator must provide a detailed explanation of the potential participant's choices and needs in the service plan, including information regarding relationships, desired living situation, recreation or community inclusion time activities, physical and mental strengths or limitations, spiritual needs and goals for vocational training, employment or community service. A description of why the waiver services are needed to prevent placement in a nursing home must also be included. The Initial Service Plan (ISP) will identify services for the first year of waiver participation.

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):

There are two types of Service Plans utilized by the TBI waiver: Initial Service Plan (ISP) and Revised Service Plan (RSP). Both documents may be updated or amended by an Addendum to the existing service plan. The RSP is revised/rewritten annually. The Service Coordinator (SC) is responsible for completing the ISP/ RSP.

The RRDS provides information about the waiver services and waiver service providers to waiver applicants. The RRDS explains to the applicant that he/she has a choice of all waiver service providers and encourages the waiver applicant to interview SC agencies in order to make an informed choice.

The applicant signs a Service Coordination Selection Form indicating that he/she understands that he/she is entitled to choose a SC and choose approved providers for other waiver services.

The RRDS forwards the Service Coordinator Selection form to the selected provider for their signature, indicating that they are willing and able to accept the applicant.

The applicant, and anyone he/she may choose, works with the Service Coordinator to develop an Initial Service Plan and complete the Application Packet.

The SC must identify and coordinate all non-waiver services deemed appropriate and necessary for the applicant. If the applicant is not currently receiving necessary non-waiver services, the SC must work with him/her and all necessary partners to obtain any necessary referrals, assessments and approvals/authorizations.

If the applicant/participant is currently receiving non-waiver services, the SC must work with the individual and all

necessary parties to obtain any necessary referrals, re-assessment and re-approvals/re-authorizations for the potential continuation of these services.

It is the SC's responsibility to maintain a current understanding of the processes required to obtain necessary referrals, re-assessments and re-approvals for non-waiver services.
This includes understanding which services under Medicaid require a physician's order and re-authorizations. When Service Plans include State Plan services, the SC must work closely with the LDSS assuring there is no duplication of services and that roles and responsibilities are clearly defined.

The SC reviews the services with the waiver applicant and presents options for meeting his/her needs and preferences. Once the individual is enrolled in waiver services, the SC monitors the provision of all services in the service plan.

The service plan reflects coordination between all providers involved with the participant. It is necessary to obtain input from agencies directly or indirectly involved in the provision of services. Participant choice is inherent to the service plan development process. The SC is responsible for providing unbiased and comprehensive information to the participant about available services and service providers. This includes a summary of all waiver services available to the individual.

The ISP contains an assessment of the individual's strengths, limitations, and goals. It identifies what services are necessary to support and maintain the individual in the community. For waiver applicants residing in a nursing/rehabilitation facility or hospital, the ISP includes current summaries of all services provided and a discharge summary from the facility, including relevant medical reports and assessments.

Also included in the plan is a detailed explanation of the potential participant's choices and needs and a description of why the waiver services are needed to prevent institutionalization or re-entry to an institution. The ISP identifies the recommended services for the first twelve months of waiver participation.

The applicant/participant is the primary decision-maker in the development of goals, and selection of supports and individual providers. The completed and approved plan is designed to address needs associated with the waiver participant's health and welfare, increase independence, productivity, and an ability to return to or remain in the community.

The Service Coordinator sends the completed Application Packet and any supporting documentation to the RRDS.

The RRDS reviews the Application Packet and either approves the applicant for waiver eligibility or requests, in writing, revisions and/or additional information needed for approval or denies the application.

A Notice of Decision (NOD) is issued by the RRDS for an approved waiver applicant. The Notice of Decision indicates the start date for the initial twelve months of waiver participation. Ongoing program participation is based on the participant's choice to remain in the waiver, continued Medicaid and level of care eligibility, and the completion of subsequent Revised Service Plans on an annual basis and approval by the RRDS. Every NOD includes information regarding an individual's fair hearing rights. The RRDC notifies Local Departments of Social Services (LDSS) office of the participant's date of waiver eligibility.

A Notice of Denial is sent when an individual is not eligible to receive waiver services.

Service Plans are expected to evolve as the participant experiences life in the community, requests revisions, experiences significant life changes, or as new service options become available.

Each service plan includes an assessment of the individual to determine the services needed to prevent institutionalization or return to a facility. This assessment includes demographic information, description of the individual in person centered terms, psycho-social history and a needs assessment.

The assessment also includes an evaluation of risk factors that will be addressed in the Plan for Protective Oversight (PPO). The PPO explicitly states the individuals who are responsible for assisting the waiver participant with daily activities/emergencies, medication management, financial transactions, fire/safety issues and back-up plans are also included. The PPO establishes a plan to reduce risk and address safety issues. The PPO addresses back-up issues for activities which are directly related to health and welfare.

The UAS-NY not only establishes NFLOC but offers a summary of the individual's strengths, weaknesses and level of

functioning. This information is incorporated into the service plan as identified training or support goals.

Assessments are completed by service providers or additional outside assessments may be procured on behalf of the applicant/participant. The RRDS reviews each service plan to assure it meets the assessed needs of the participant and reflects waiver participant choice.

A formal review must be conducted on an annual basis when the RSP is due. Other events which may trigger a review include:
• The participant requests a change in services or service providers;
• There are significant changes in the participant's physical, cognitive, or behavioral status;
• A new provider is approved or the participant is interested in either changing providers or adding newly available services; and
• The expected outcomes of the services are either realized or need to be altered.

The service plan identifies services for one year of waiver participation. If the waiver participant's level of skill changes, there is an appropriate adjustment in the type and amount of the waiver services provided and an addendum to the plan is executed. The SC develops the Addendum in collaboration with the participant, authorized representatives, and specific service provider(s) whenever there is a change needed in identified services, frequency or duration of a service.

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 provided when informal or formal supports are not available to meet the participant's needs. Waiver services may also be accessed when it is more efficient or cost-effective than Medicaid State Plan services.

Each service plan identifies the participant's primary care physician, and other medical providers. Medications are listed and reviewed as part of the service plan development. Assessments may indicate medical follow-up or additional services and this information is explained and identified in the service plan. Supportive services are developed around the individual's medical and behavioral needs.

All medication regimes are reviewed on an annual basis in conjunction with the service plan, upon discharges from hospitals and rehabilitative services or when the needs/conditions of the participant change significantly.

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 includes the description of methods for addressing the participant's goals and objectives and identifies persons and/or services responsible for implementing and monitoring the plan. These methods are discussed and evaluated at each service plan review.

The Revised Service Plan (RSP) is due to the RRDC at least sixty (60) days prior to the last day of the twelve months of the most recently approved service plan. An update to the service plan is developed in the following situations:
At least every twelve months if the participant chooses to continue waiver services;
When a participant has been institutionalized or hospitalized for an extended period;
Any time there is a need for a significant change in the level, type or amount of services.

The RSP contains a review and evaluation of the participant's previous twelve months of waiver services. It addresses how waiver services continue to prevent institutionalization and indicates whether these services should continue unchanged, be modified or discontinued.

Individual Service Reports (ISR) are required by the Service Coordinator for the development of the RSP. The Service Coordinator is responsible for informing the waiver service providers that the ISR is due.
The ISR documents the progress of the participant in relation to provided services, justifies the continuation of the services and represents the provider's request for continued approval to provide the services. In order for the RRDS to justify approval/continuation of a service, the ISR must clearly describe how the continuation of this service will help to maintain the participant in the community.

The RSP must be reviewed and signed by the participant, the SC and the Service Coordinator's Supervisor before being forwarded to the RRDS for final review and sign-off.

To assure services are provided in the most integrated and efficient manner, providers attend regularly scheduled (at least every six months) Team Meetings to discuss progress toward the participant's goals, identify any impediments to

achieving projected milestones and address any issues affecting the participant. Regularly scheduled Team Meetings with the participant and service providers are an essential part of assuring the participant's health and welfare. There must be at least one Team Meeting every six months from the date of approval of the service plan.

The service plan (RSP) is re-written and approved by the RRDC annually, reviewed every six months at a Team Meeting, 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. The RRDS reviews the Team Meeting Summaries and if necessary, informs the SC of required changes in the service plan and the need for an addendum.

Schedules included with the service plan serve as proposed time frames for service delivery and are dictated by the participant. Providers are required to remain within the total approved hours on an annual basis and not a bi-weekly schedule. RRDCs maintain monitoring mechanisms to review usage to ensure that services are provided on a timely basis.

The applicant's/participant's signature is required on the Initial Service Plan, the revised service plans, and any addenda to the service plan. The participant's signature indicates that he/she has contributed to the development of the service plan, and agrees with the information that is included in the service plan, the services requested and the chosen providers of the services. By signing the service plan, the waiver participant acknowledges that he/she was actively involved in the development of the plan.

If the participant does not want to sign the Service Plan, the waiver participant is given the opportunity for a conference with the RRDC and/or a Fair Hearing.

The RRDS conducts a comprehensive review of all submitted service plans and completes the RSP Review form assuring the plan meets the participant's needs that allow the individual to live safely in the community. The RRDS may request amendments to the plan and return it to the Service Coordinator for revision. The participant must be advised of any changes to the plan. Upon receipt of the final version of the plan from the Service Coordinator, the RRDS reviews and approves the RSP, documenting the effective date of the new service plan period.

The Service Coordinator is responsible for ensuring that all service providers receive a copy of the approved service plan and are aware of the overall plan and goals. The approved plan must be forwarded to each waiver service provider or service provider agency within three (3) calendar days of receipt by the Service Coordinator.

The SC regularly reviews the service plan with the participant. This review is a natural component of the monthly meetings between the participant and Service Coordinator.

Late submission of a service plan can result in the interruption of services to a participant and penalties to the provider agency.

Participants are surveyed using a statewide satisfaction survey tool to obtain feedback about the services and supports that they receive through the TBI waiver. This survey includes questions about the waiver participant's satisfaction with the amount of choice and control that the participant has over his or her services and service providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The TBI waiver recognizes the waiver participant's right to risk and the dignity to fail, and balances this with the State's responsibilities to assure health and welfare, and the waiver participant's right to select their services and providers. It is critical to obtain an accurate assessment of the needed supports and services necessary 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 service provider, and the UAS-NY assessment, 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 and the extent of that risk. 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 Instruments of Activities

of Daily Living (IADLs). The waiver participant has the right to accept or reject assistance or modifications to these activities.

Every service plan and addendum also includes a signed Plan of Protective Oversight (PPO). The PPO explicitly identifies the individuals who are responsible for assisting the waiver participant with daily activities, medication management, financial transactions, fire/safety issues and back-up plans for emergencies. The PPO establishes a plan to reduce risk and address safety issues. The PPO addresses back-up issues for activities which are directly related to health and welfare. The SC is responsible for assuring that the activities outlined in the PPO are consistent with assessed needs and is properly implemented.

Review of Serious Reportable Incidents, complaints and staff notes also provide indicators of participant risk while living in the community. Participant risk and safety considerations are identified and potential interventions considered. When necessary, additional service referrals may be made to address risk issues and/or behavioral interventions identified.

When the waiver participant's choices are such that the waiver program is not able to assure the waiver participant's health and welfare in the community, the RRDC may deny waiver services. The waiver participant may present a risk to his/herself, staff, family and informal supports. This concern is discussed with the waiver participant and all involved parties. In addition to the participant, all waiver service providers are invited to attend Team Meetings. Team Meetings are held at least every six (6) months when the service plan is reviewed and can be arranged any time to address health and safety concerns.

During service plan development, risk factors and safety considerations are identified by the Service Coordinator, the participant, family members and treating professionals. Interventions such as PERS or other assistive technology devices, new services such as HCSS, or environmental modifications to minimize isolation, are incorporated into the service plan with consideration of the participant's assessed preferences. Individuals, family members and/or designated others participate in the service plan development to assure identification of realistic strategies that will mitigate foreseeable risk with consideration of the participant's unique desires and goals.

The Plan for Protective Oversight (PPO) indicates all activities that directly impact the health and welfare of the participant and clearly identifies the individual(s) responsible for providing the assistance. The PPO must be included with an ISP, RSP and Addendum. Any PPO must be signed and dated by all the individuals listed as supports to the waiver participant.

The PPO supplements the service plan by identifying resources and activities that assure the health, welfare and safety of the participant. The PPO documents all key individual(s) responsible for providing the needed assistance to the participant in the event of an emergency or disaster and identifies activities that may pose a challenge or problem for the participant.

The PPO must be completed by the Service Coordinator with the applicant/participant during the development of the service plan. It is signed and dated by the applicant/participant, Service Coordinator, and all individuals listed as Informal Supports. The PPO is attached to the service plan packet for RRDS review and approval, and is amended as needed.

In addition, the PPO must be reviewed by the Service Coordinator with the participant at each Addendum. If there are no changes to the PPO, the participant and the Service Coordinator sign the last page of the Addendum indicating that the PPO was reviewed and there were no changes. The PPO is attached to the Addendum for RRDS review.

The Service Coordinator is responsible for assuring effective communication between the participant and all service providers. Should any information regarding the participant's situation change that directly affects information in the PPO, the Service Coordinator is responsible for amending the PPO and acquiring new signatures from the participant and any individuals listed as Informal Supports to the participant.

A copy of the approved PPO is provided by the Service Coordinator to the participant and to each waiver service provider listed in the current service plan. The PPO must be maintained in the participant's record.

To assure services are provided in the most integrated and efficient manner, it is necessary for providers to attend regularly scheduled Team Meetings to discuss progress toward the participant's goals, identify any impediments to achieving projected milestones and address any issues affecting the participant. Regularly scheduled Team Meetings with the participant and service providers are an essential part of assuring the participant's health and welfare.

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 application process and the approved service plan period. Participants are informed of this right during discussions with the RRDS, during the development of the service plan, upon signing of Waiver Participant Rights Form and periodically by the Service Coordinator.

The RRDS is responsible for providing the waiver participant with a list of Service Coordinators and providers and encourages participants to make their selections based on their personal knowledge and research of a provider and/or upon interview.

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 assists the waiver participant to do so. In the TBI Program Manual there is a process outlining the steps to facilitate transition to a new provider.

Should the RRDC receive complaints regarding the quality of service provision from a participant, the RRDC will assist the participant in resolving the problem and offers a change in provider as an option for the participant.

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):

NYSDOH monitors service plan development in accordance with its policies and procedures through protocols clearly defined in the TBI Program Manual: Section V Service Plan. This multi-level process includes the participant, Service Coordinator, waiver service providers, RRDS, and NYSDOH. The TBI Program Manual outlines specific procedures with timelines for each level of service plan development, review and approval.

There are multiple review processes of service plans. The RRDC reviews and approves one hundred percent (100%) of all service plans. The reviews are documented on the service plan review sheet which is also distributed to Service Coordinators as a mechanism to indicate areas in need of revision or questions the RRDC may have regarding the content of the service plan. These review sheets are subject to review by NYSDOH waiver management staff at the time of the annual site visit.

On a monthly basis, NYSDOH waiver management staff review the number of service plans reviewed by the RRDC, the number of pending service plans and the number of service plans approved. This allows NYSDOH waiver management staff to identify the flow of work and timeliness of the approvals.

The RRDC conducts an annual record review of files. Included in this review is a historical review of service plan information and the most recent service plan including but not limited to: Team Meeting minutes, cost projection grids, signature pages, PPOs and ISRs. NYSDOH waiver management staff conduct a review of the self-audit documents to confirm validity of reporting data.

The participant satisfaction survey includes questions related to service plan development and the reliability of service delivery.

NYSDOH waiver management staff monitor information included in the statewide database to establish timeliness of service plans, identify services and service providers and to monitor costs of waiver services. An annual audit of the database is completed by NYSDOH waiver management staff.

NYSDOH waiver management staff perform a random retrospective review of service plans, to compare each waiver participant's service plan with paid claims to verify that the provided waiver services are authorized in the service

plan. NYSDOH has the ability to examine the claim detail reports of a participant. This report is an accounting of all Medicaid expenditures for services provided to a participant. This report may be compared to the service plan to identify discrepancies between services approved, provided and billed to Medicaid.

Sample size for the reviews are based on statewide and regional enrollment using the Raosoft sample size calculator with a 95% confidence level and a 5% margin of error and the random sample is established using Random.com. If significant deficiencies or trends are identified, the sample size and the scope of the review may be amended or expanded.

The Service Coordinator is responsible for tracking and informing waiver service providers that the RSP is due.

A complete, acceptable Revised Service Plan (RSP) is submitted to the RRDS for approval at least sixty (60) calendar days prior to the last day of the twelve-month period of the current service plan. Late submission of the RSP by the Service Coordinator can result in the disruption of services to a participant and potentially lead to administrative action by NYSDOH.

The RRDS conducts a comprehensive review of all submitted service plans and completes the RSP Review form assuring the plan meets the participant's needs that allow him/her to live safely in the community. The RRDS may request amendments to the plan and return it to the Service Coordinator for revision. Upon receipt of a final version of the plan from the Service Coordinator, the RRDS reviews and approves the RSP, documenting the effective date of the new service plan period.

Services in a service plan cannot be initiated until approval is given by the RRDS; service changes or additions proposed in an RSP cannot be initiated without approval from the RRDS.

NYSDOH waiver staff monitor entries in the TBI database and monthly reports to assure timely development and review of service plans.

NYSDOH waiver staff track trends in complaints/concerns regarding service delivery by participants via regional RRDC complaint lines.

During RRDC site visits and/or by monitoring RRDC self-audits/retrospective file reviews, NYSDOH waiver staff review a sample of active participant records for compliance.
NYSDOH dictates the process for the RRDC self-audit of records. The RRDC identifies the sample criteria. NYSDOH identifies the sample size. NYSDOH provides the RRDC with an audit checklist. Within timeframes established by NYSDOH, the RRDCs review the files and provides NYSDOH with a summary of their findings using the format established by NYSDOH. NYSDOH takes the regional data and aggregates the data on a statewide basis. NYSDOH identifies any trends and remedial action and makes the appropriate procedural adjustments.

Waiver service providers' participant records are reviewed during surveys conducted by NYSDOH Office of Primary Care and Health Systems Management (OPCHSM).

NYSDOH waiver staff monitor fair hearings generated as a result of the denial or reduction in waiver services.

NYSDOH waiver staff monitor the findings of RRDC participant satisfaction surveys in order to identify issues and trends related to the delivery of waiver services.

NYSDOH waiver staff monitor the number of pending intake, referrals and service plan reviews completed on a monthly basis.

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

- [ ] **Medicaid agency**
- [ ] **Operating agency**
- [x] **Case manager**
- [x] **Other**

Specify:

Regional Resource Development Specialist
Service Coordination Agency
Approved Providers

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.

NYSDOH assures that services are delivered in accordance with the service plan, including type, scope, amount and frequency specified in the service plan. Providers maintain documentation of participant outcomes. Such documentation is in the form of outcome measurements or documentation of success in goal attainment or encounter date from one service plan period to the next. Review of service notes, Individual Service Reports (ISRs) and Detailed Plans are completed by the SC and RRDC to determine if the participant's goals are met. Each waiver provider is responsible for the delivery of services in accordance with the approved service plan. This information is also reviewed upon survey by the Office of Primary Care and Health Systems Management (OPCHSM) and upon audit by OMIG/OIG.

Upon approval by the RRDS, the Service Coordinator is responsible for ensuring that all service providers receive a copy of the approved service plan and are aware of the overall content of the plan and goals. The approved plan is forwarded to each service provider within three (3) calendar days of receipt of the approved plan by the Service Coordinator. The provider must be in receipt of the approved plan prior to implementing services.

The Service Coordinator regularly reviews the plan with the participant. This review is a natural component of the monthly meetings between the participant and Service Coordinator. As with all waiver services, Service Coordination is included in the service plan with, at a minimum, one face-to-face contact with the participant per month. At least quarterly, one of these visits must occur in the participant’s home in order to assure receipt of required care.

Participants are informed by the Service Coordinator of his/her right to contact any waiver entity when there are concerns regarding the delivery of services. All waiver providers are responsible for maintaining open communication with the Service Coordinator when concerns or changes with the participant occur that potentially affect the provision of services.

The participant and their legal guardian, if applicable, reviews and signs the written plan before the Service Coordinator submits it to the RRDS for review. The service plan is also signed by the Service Coordinator and the Service Coordinator’s supervisor prior to submission to the RRDC. Services are not implemented without a signed and executed service plan.

Each TBI waiver service provider executes an agreement with NYSDOH to confirm agreement with NYSDOH policies and procedures. Addendum II of this agreement provides that the Provider must oversee the provision of services to ensure that quality services are delivered in a timely manner and in accordance with the service plan. Services must be provided in accordance with the participant’s assessed needs, accepted standards of quality and effectiveness, and the

provider's recognized scope of practice.

The RRDS also meets, as needed, with a participant's service team to discuss the provision of services and monitors service plans. The RRDS reports any major problems that affect waiver participants' health and welfare in their quarterly report to NYSDOH waiver management staff or contacts NYSDOH for technical assistance with service issues.

Access to non-waiver services is identified in the service plan and is facilitated by the Service Coordinator. The Service Coordinator is required to complete a monthly face-to-face meeting with the participant. At that time they review the month's service activities and outcomes. The Service Coordinator may also follow-up with service providers (waiver and non-waivered) to discuss follow-up or additional service needs. The participant's progress is monitored against the goals and services identified in the service plan on an on-going basis. Every service plan includes a Plan of Protective Oversight (PPO). The RRDC reviews every PPO as part of the service plan approval. Any failure in a back-up plan is reported through the Serious Reportable Incident process and through incident investigations.

Providers notify the Service Coordinator when a participant repeatedly refuses a service or repeatedly asks that the service be rescheduled. The Service Coordinator reviews the service plan with the participant to determine if it needs to be revised to more accurately reflect the goals and abilities of the participant and/or scheduling issues. Revisions to the schedule should allow enough time for the provider to make the necessary arrangements. When a participant refuses all waiver services, it is necessary to evaluate his/her continued participation in the waiver. Waiver participants must actively participate in waiver services in order to maintain eligibility.

NYSDOH waiver staff retrospectively review a random sample of service plans. Services identified in the service plan are compared to billing information indicating actual services utilized and billed. This information is compiled to determine the accuracy of service identification contained within a service plan. NYSDOH waiver management staff inform the RRDS regarding any interventions that are needed at the provider or regional level.

Service plans are also monitored through the Participant Satisfaction Survey conducted by the RRDC on an annual basis. As part of this survey, waiver participants are asked if they know the contents of their service plan and have a copy. These results are compiled and evaluated for trends. Participants are also asked if services are delivered as established in their service plans.

In addition, each waiver service provider agency conducts their own participant satisfaction survey to ascertain the experiences of the waiver participants that they serve. The SC works with the waiver participant to remedy any problems that are identified through the survey process.

Monitoring of the service plan is also done through the Incident Reporting process. All Serious Reportable Incidents (SRIs) are reported to the SC and the RRDC. When an SRI involves issues affecting the waiver participant's health, such as unplanned hospitalizations or medication errors/refusals, follow-up includes the SC working with the waiver participant to review the service plan to see if an addendum or revised service plan is necessary. The RRDC includes data on SRIs in a quarterly report to NYSDOH waiver staff. This data is compiled to identify statewide trends.

NYSDOH waiver staff receive complaint calls from participants, legal guardians or other designees regarding provision or access to services. Depending on the nature of the complaint, NYSDOH waiver staff notify the appropriate RRDC staff, DOH Regional Surveillance Unit and/or makes other referrals as deemed necessary.

NYSDOH surveys TBI waiver service providers every three years. Waiver service providers maintain billing and personnel records as well as participant service plans which are subject to review.

Comprehensive billing audits are completed by the NYS Office of Medicaid Inspector General (OMIG) of waiver service providers. This review includes billing information and supporting documents to compare needed service identification to service utilization.

All waiver participants have a choice of their waiver service providers. The waiver participant may change their waiver service providers at any time during the approved service plan period, including Service Coordinators. If a waiver participant chooses to change a waiver service provider, a Change of Provider form is completed. The RRDC approves all requests for Change of Providers.

On an annual basis, the waiver participant reviews and signs the Participant's Rights and Responsibilities Form, which describes the right to choose and change providers as requested. Waiver participants maintain a copy of the signed form, as does the RRDC.

Providers must be approved by NYSDOH for each service they wish to provide and are monitored by the RRDC and the OPCHSM. Annual NYSDOH surveys, audits, and retrospective reviews are completed. Waiver participant satisfaction surveys are conducted by the RRDCs and providers.

The RRDC and NYSDOH monitor the provision of services to ensure compliance with COI standards.

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.

RRDSs also make random home visits to participants to discuss complaints or address service issues.

b. Monitoring Safeguards. *Select one:*

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percentage of service plans that adequately ensure the health and welfare of waiver participants by including a complete and accurate Plan of Protective Oversight (PPO) (percentage= numerator: number service plans that included a complete and accurate plan of protective oversight as determined by the RRDC/ denominator: total number of service plans reviewed by the RRDC)

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
Number and percentage of service plans reviewed by the RRDC and returned to the Service Coordinator for revision on or before the participant's annual review date (percentage = numerator: number of service plans returned for correction prior to approval/ denominator: total number of approved service plans)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
The RRDS reviews each service plan. The service plan is returned to the SC for amendment when the document does not sufficiently meet NYSDOH requirements.

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of service plans timely submitted and approved in accordance with the TBI Program Manual (percentage = numerator: service plans approved every twelve months/ denominator: total number of submitted service plans)

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

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

RRDC		
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and percentage of services that are delivered in accordance with the service plan including type, amount, scope, duration and frequency (percentage = numerator: total paid claims for sampled plans consistent with the service grid included in the service plan/ denominator: total number of sampled plans)

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

NYSDOH waiver management staff conduct reviews of service plans against paid claims data acquired through Electronic Medicaid System of New York (eMedNY).

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a 5% error margin http://www.raosoft.com/samplesize.html
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Participant Satisfaction surveys are conducted by providers and the RRDC. This information is subject to review by the NYSDOH Surveillance staff and NYSDOH waiver management staff.

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

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

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percentage of participant records that contain Freedom of Choice forms, Service Coordination Selection forms and Provider Selection forms signed by the participant and/or their legal guardian (percentage = numerator: total number of current service plans with the required documents signed by the participant/ denominator: total number of current service plans)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Retrospective file review

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

collection/generation *(check each that applies):*	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a 5% error margin http://www.raosoft.com/samplesize.html
☑ **Other** Specify: RRDC	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
The RRDC reviews one hundred percent (100%) of all service plan packets received.

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

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
NYSDOH monitors correct completion of the Applicant Interview and Acknowledgement, Freedom of Choice, Service Coordinator Selection, Provider Selection, Participant Rights and Responsibilities forms.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a 5% error margin http://www.raosoft.com/samplesize.html
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. Each Service Coordination agency must maintain a system for tracking service plan type (ISP/RSP), completion dates, and revision due date to assure there is no lapse in time between service plan periods. The tracking system is reviewed during survey of the agency by NYSDOH Surveillance staff.

Each RRDC maintains a database for tracking service plan periods, service plan type (ISP/RSP), service plan due dates, and type of Notice of Decision (NOD) issued.

RRDC staff report the status of service plan reviews on a monthly basis to NYSDOH.

RRDCs generate reports from the database of upcoming and overdue service plan reviews. On an annual basis the RRDC completes a record audit of a statistically reliable sample of files to assess compliance. Regional data is provided to NYSDOH waiver management staff who complete a statewide aggregate summary.

The Office of Primary Care and Health Systems Management (OPCHSM) completes surveys of approved providers and reviews service notes. The provider must document each encounter with the participant. Survey results are posted on ASPEN.

The Office of the Medicaid Inspector General (OMIG) has established protocols for the review of TBI provider payment records as per NYSDOH Medicaid Update January 2005, Vol 20, No1, OMM. OMIG reports are posted on its website.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Compliance rates for specific performance measures are established and reviewed with the RRDCs at a quarterly meeting.

Each RRDC develops a plan to remedy any regional deficiencies identified through performance measure reviews. A time frame to remedy the deficiency is established by NYSDOH.

NYSDOH waiver management staff assist with the remedy by conducting site visits, offering training, linking the RRDC with another successful RRDC to discuss systems and improvements.

NYSDOH ensures remedial actions are effective by completing a comparative analysis of aggregated data between the previous year and the current year.

Review of monthly and quarterly reports offers an ongoing summary of performance measures.

RRDC staff develop internal procedures to ensure participant choice and adequate services are provided in a timely manner. The providers are also required to respond to the participant's request for services in a timely manner. RRDC staff, in addition to Surveillance staff, complete site visits to providers and offer technical assistance.

Performance measures such as the Participant Satisfaction Survey and complaint processing are continuously refined to better measure participant feedback regarding services.

Quality improvement activities are discussed at quarterly RRDC meetings and monthly conference calls.

Forms and procedures are modified to facilitate a better work product from Service Coordinators and increase

involvement by participants.

RRDCs utilize provider meetings as training opportunities to enhance skills and understanding of protocols.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

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

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

An individual has the right to seek a Medicaid Fair Hearing for many reasons including issues related to the HCBS/TBI waiver. Decisions regarding Medicaid eligibility are addressed through the fair hearing process with the local Department of Social Services. As established in 18 NYCRR 358, the NYS Office of Temporary and Disability Assistance (OTDA) Office of Administrative Hearings presides over the fair hearing process.

A Notice of Decision (NOD) is provided by the Regional Resource Development Center (RRDC) when a participant is determined eligible for waiver services; denied or discontinued from waiver services; or waiver services are added, increased, decreased or discontinued. The provider must adhere to the effective date of the decision when implementing or terminating services for a participant. The RRDC approval of a service plan authorizes the provision of services documented in the plan.

Individuals receiving a Notice of Decision (NOD) for issues related to the waiver are eligible for a fair hearing and, in certain circumstances, may request aid to continue (18NYCRR 358-3.6: The right to have assistance or services continue unchanged until the Fair Hearing decision is issued). All NODs include information regarding an individual's fair hearing rights. For example, included is the statement: "If you do not agree with this decision, you can ask for a conference, a fair hearing or both. Please read the back of this notice and find out how you can request a conference and/or a fair hearing".

The NOD confirms the following participant rights:
Right to a conference with the RRDS to review the actions implemented as a result of the NOD.
Right to request a fair hearing if the participant believes the action is wrong.
The methods and time frames to request the fair hearing.

The notice also provides guidance for acquiring free legal assistance and explains how the participant may gain access to his/her file and secure copies of documents.

A Notice of Denial/Discontinuation will be provided when an individual is not eligible to receive waiver services for such reasons including but not limited to:
• NYSDOH/RRDC establishes the applicant/participant chooses not to receive waiver services.
• NYSDOH/RRDC establishes the applicant/ participant is not between the ages of 18-64 upon application.
• NYSDOH/RRDC establishes the applicant/ participant is not able to provide medical verification/documentation to support a diagnosis of Traumatic/Acquired Brain Injury.
• NYSDOH/RRDC establishes the applicant/participant is not a recipient of Medicaid coverage that supports community based long term care services.
• NYSDOH/RRDC establishes the applicant/participant is not able to identify an HCBS compliant community residence where waiver services will be provided.
• NYSDOH/RRDC establishes that informal supports, non-Medicaid supports, State Plan Medicaid services, and/or waiver services are not sufficient to safely serve the individual in the community.
• NYSDOH/RRDC establishes that the applicant/participant does not require nursing home level of care as a result of their traumatic/acquired brain injury based on the LOC assessment.
• NYSDOH/RRDC establishes the services and supports available through the waiver and all other sources are not sufficient to maintain the individual's health and welfare in the community.
• NYSDOH/RRDC establishes the applicant/ participant chooses to receive services or may be more appropriately served by another Home and Community Based Services Medicaid Waiver.
• NYSDOH/RRDC establishes the participant is hospitalized for more than 30 days and there is no scheduled discharge date.
• NYSDOH/RRDC establishes the participant is admitted to a nursing home, psychiatric, rehabilitation, assistive living or other congregate care/institutional setting for other than a short term.
• NYSDOH/RRDC establishes the participant is incarcerated for more than 30 days.
• NYSDOH/RRDC establishes the participant is residing outside the State of New York for more than 30 days.
• NYSDOH/RRDC establishes the participant is not actively participating in waiver services and/or does not receive Service Coordination monthly.

The right to conference/administrative meeting provides for the following:
Applicants/Participants may have a conference with the Regional Resource Development Specialist (RRDS) to review the actions established in the NOD.
The applicant/participant or his/her legal guardian is also informed that requesting a conference is not a prerequisite/or substitute for a Fair Hearing.

At the conference, if the RRDS discovers that an incorrect/inaccurate decision was made or because of additional information provided by the applicant/participant, the RRDS may reverse the decision or arrange a settlement. Upon agreement, a new NOD will be issued. Through discussion and negotiation, it may be possible to resolve issues without a Medicaid Fair Hearing. Applicants/Participants that ask for a conference are still entitled to a fair hearing.

Applicants/Participants may request a State Fair Hearing by calling a statewide toll free number (1-800-342-3334), faxing a copy of the notice (on the back of the NOD) to OTDA or by mailing the request to OTDA.
When seeking services while the fair hearing process proceeds, the participant must request aid continuing from the New York State Office of Temporary Disability Assistance. NYCRR Title 18 358-2.5 Aid continuing: Aid continuing means the right to have public assistance, medical assistance, food stamp benefits or services continued unchanged until the fair hearing decision is issued.

Applicants/Participants have sixty (60) days from the date of the notice to request a fair hearing. OTDA notifies the appellant of the time and place of the hearing at least ten (10) calendar days prior to the hearing date.

Applicants/Participants are notified that they have the right to be represented by legal counsel, a relative, a friend or other person or to represent themselves.

At the hearing appellants are afforded the opportunity to present written or oral evidence to demonstrate why the action should not be taken as well as the opportunity to question any persons who appear at the hearing.

In preparation for the hearing, applicants/participants are advised they have a right to review their file. The RRDS will provide the appellant with copies of documents from their file which may be required for the hearing. Documents may be mailed or are available for review at the RRDC.

Appellants have the right to bring witnesses to speak in favor of their position. Any documents that may be helpful in supporting the appellant's case may be presented.

Applicants/Participants are advised they may be able to obtain legal assistance by contacting the Legal Aid Society or other legal advocacy groups.

The Applicant Interview Acknowledgement Form signed by the Applicant and/or Legal Guardian or Authorized Representative informs the applicant/participant of his/her rights to a Fair Hearing.

The Waiver Participant Rights and Responsibilities Form signed by the applicant/participant upon waiver eligibility and annually thereafter advises the applicant/participant of their right to a Fair Hearing. The Service Coordinator must review the Participant Rights and Responsibilities form with the applicant/participant and it is signed and dated. A copy is given to the applicant/participant to be maintained in an accessible location in the home. This form includes the participant's right to choose between and among waiver services and providers.

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:

The RRDC is responsible for receiving complaints and grievances on the regional complaint phone line. Approved TBI service providers must also establish a method for receiving and addressing complaints. NYSDOH also receives complaints and monitors the response and outcomes of the RRDC and provider complaint processes.

The following information is on the participant's Waiver Contact List which is maintained in the participant's home:

Waiver Complaint Line-(Name of RRDC)
NYS Department of Health TBI Waiver Program
NYS Department of Health Home Care Complaint Line (LHCSA issues)
NYS Department of Health Medicaid Helpline
NYS Office of Temporary and Disability Assistance Fair Hearings
NYS Justice Center
Poison Control Center

Additionally NYSDOH maintains the following call centers:
Adult Home Complaint Hotline
Home Care/Hospice Hotline
Nursing Home Abuse Hotline

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).

A complaint may include issues regarding the type, delivery and frequency of services, problematic issues regarding the RRDC staff, SC, waiver service providers, or general concerns about the waiver program. Participants may file complaints regarding service providers, the quality of services provided and the frequency and duration are investigated. The complaint lines receive any complaint that an individual may have regarding their services and/or service providers, RRDC performance and other issues of concern.

Each Regional Resource Development Center (RRDC) maintains a designated phone line to accept complaints on behalf of TBI Medicaid waiver participants about the services they receive. Participants are encouraged to discuss their concerns with their SC or to file a complaint using the specific RRDC complaint number listed on their Waiver Contact List.

If the subject of the complaint is the RRDC, TBI waiver management staff will address the complaint or initiate an independent review of the matter. Participants are provided the phone number for the NYSDOH TBI Program waiver management office on their Waiver Contact List (518-474-5271). If the individual cannot make this call because it is a long-distance toll call, they are encouraged by their SCs to call the RRDC and ask that the NYSDOH TBI Program return their call.

The New York State Department of Health (NYSDOH) also operates a Home Health Care Hotline that affords individuals the opportunity to register grievances or complaints about the services they receive. Participants are provided a toll-free hotline at 1-800-628-5972 to register a complaint. All complaints are then forwarded to the NYSDOH Regional Office in which the service provider is located or to TBI waiver management staff.

Section III of the TBI Program Manual establishes that providers must satisfy the following conditions:
Assure participant's right of choice; Establish and maintain a process for surveying participant satisfaction of their service. This process includes obtaining information from the participant about his/her satisfaction of the service provided, staff availability to make appointments, timeliness and whether services are provided as agreed upon in the service plan.

A participant's safety must always be the primary concern of the provider agency, Service Coordinator and the RRDC. Whatever measures appear to be reasonable and prudent to ensure the protection of a person from

further harm, injury, or abuse, and to provide prompt treatment or care are taken. When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused a person shall be removed from direct contact and immediate proximity to, or responsibility for, the participant.

Each provider must also establish and maintain a method for recording and addressing complaints made by waiver participants, families, legal guardians and others; this information is included in an annual report stating the number and types of complaints made/received, including an analysis of these complaints and the provider's response.

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.

The RRDC or NYSDOH waiver management staff responsible for follow-up of complaints or grievances contact the complainant to acknowledge receipt of the complaint and to advise that review of the matter is in process. The final outcome of the complaint review is communicated in writing to the person initiating the complaint, as appropriate and allowed by HIPAA. The protocol is as follows:

1. The RRDC accepts the call, identifies the caller and presents the issues on behalf of the caller in a clear, concise and objective manner on the Complaint Intake Form.

2. The RRDC presents the complaint on the Complaint Intake Form. All fields of the form are completed and the status of the waiver participant confirmed via the TBI Waiver database.

3. The RRDC staff responsible for the complaint follow-up, contacts the participant within two business days of receipt of the complaint and advises that the complaint has been received and review/investigation is in process.

4. If the RRDC determines the matter to be a Serious Reportable Incident (SRI), the complaint is reclassified by the RRDC as an SRI. Within forty-eight (48) hours after identifying the matter as a Serious Reportable Incident, the RRDC assigns the incident to the appropriate investigating agency- i.e. Service Coordination agency, Service Provider (ILST, CIC) to begin a review of the incident. The investigating agency begins an immediate investigation and provides an initial follow-up report within seven (7) days of the incident assignment. The RRDC sends a letter to the complainant advising him/her of the reclassification of the complaint to an SRI.

5. All complaints are tracked by the RRDC via a complaint database.

6. The RRDC contacts NYSDOH regarding any extraordinary complaints or sensitive issues within twenty-four hours of receipt of the complaint.

7. When TBI waiver management staff receive a complaint from a participant/service provider or family member regarding the RRDC or another service outside the scope of the RRDC, TBI waiver management staff are responsible to address the complaint or initiate an investigation.

8. The RRDC or responsible entity investigates the complaint. The complaint review/investigation process and report includes:
a brief description/summary of the complaint as well as
pertinent demographic information of the participant and any other people related to the complaint;
a summary of all completed interviews or statements of fact;
a summary of documents and any evidence reviewed;
a description of the investigator's findings and analysis of the event;
all corrective actions taken; and
the current status of the complaint and/or participant and any conclusions indicated by the investigation.

9. Once the investigation/review is completed, the RRDC informs the complainant of investigation findings as "Substantiated", "Unsubstantiated" or "Inconclusive", and of any implemented necessary corrective and/or preventive action. The RRDC contacts the complainant to discuss the findings.

10. The RRDC follows-up with a letter to the complainant confirming the date of the call and a brief summary of the discussed findings.

11. The Complaint Form is completed to indicate the final status and disposition of the complaint (i.e. unsubstantiated/substantiated/inconclusive) and the date the complainant was notified of outcome.

12, The RRDC tracks the status of all complaints every thirty days.

13. The RRDC provides a quarterly report of complaints, analyzing any trends and providing a summary of the complaint information to NYSDOH.

If the subject of the complaint is the RRDC or another service within the New York State Department of Health (NYSDOH), TBI waiver management staff will address the complaint or initiate review of the matter. For such complaints, please call the NYSDOH TBI Program at 518-474-5271.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A Serious Reportable Incident (SRI) is any situation in which someone has knowledge that the safety and well-being of the waiver participant is compromised. It is a significant event or situation endangering a person's well-being and because of the severity or sensitivity of the situation must be reported to the RRDC and/or NYSDOH.

Abuse: The maltreatment or mishandling of a person receiving waiver services which would endanger the physical or emotional well-being of the person through the action or inaction of anyone associated with the waiver participant whether or not the person is or appears to be injured or harmed. Abuse subcategories include: physical, sexual, psychological, seclusion, restraint, mistreatment and/or aversive conditioning.

Neglect: A condition of deprivation in which the waiver participant receives insufficient, inconsistent, or inappropriate services, treatment or care to meet their needs; failure to provide an appropriate and/or safe environment for receiving services; and/or failure to provide appropriate services, treatment or care by gross error in judgment, inattention or ignoring.

Violation of a person's civil rights: Any action or inaction which deprives a person of the ability to exercise his or her legal rights, under state and federal law.

Missing person: The unexpected or unauthorized absence of a person taking into consideration the person's habits, deficits, health problems and capabilities.

Death of a waiver participant: Death due to circumstances unrelated to the natural cause of illness or disease or proper treatment in accordance with accepted medical standards; an apparent homicide or suicide; or an unexplained or accidental death. Deaths due to natural causes must be reported to the RRDC within twenty-four (24) hours and the

RRDC will determine if it will be categorized as an SRI.

Unplanned hospitalization: Any injury or illness which results in a hospital admission of a person for treatment or observation for greater than twenty-four hours (24) due to the injury/illness.

Possible criminal action: Actions by persons receiving services which are or appear to be a crime under New York State or Federal law.

Medication error/refusal: A situation in which a person evidences marked adverse effects or a person's health or welfare is in jeopardy due to incorrect dosage, administration or refusal to take prescribed medication.

A Recordable incident is an event that does not present an immediate threat to the person and does not meet the level of severity of an SRI, but may compromise the safety and well-being of the individual if not noted, reported and addressed. These incidents warrant an internal investigation by the provider and are monitored by the provider agency's quality assurance unit for trends and outcomes. Recordable incidents are not reported to NYSDOH. These incidents are reported annually to the RRDC and are subject to review upon site visit by the RRDC and/or NYSDOH Office of Primary Care and Health Systems Management (OPCHSM). Recordable incidents may include, but are not limited to, the following:

Injury: Any suspected or confirmed harm to a person receiving services caused by an act or person accidental in nature or one that the cause cannot be identified which results in a person requiring medical or dental treatment and such treatment is more than first aid.

Death of a waiver participant: due to natural causes when in a treatment facility or hospice environment. Deaths due to natural causes must be reported to the RRDC within twenty-four (24) hours and the RRDC will determine if it will be categorized as a Recordable Incident.

Sensitive Situation: any situation related to a waiver participant that needs to be monitored for a potential adverse outcome. This includes events that attract media attention or inappropriate activity which could threaten the participant's ability to remain in the community.

Each waiver service provider has policies and procedures in place to protect the health and welfare of the participant prior to approval as a waiver service provider. Agencies are required to develop policies and procedures in accordance with the TBI Program Manual and other NYSDOH policies and procedures. This information is submitted to the Regional Resource Development Center (RRDC) for review as part of the provider enrollment process. The RRDS will contact NYSDOH waiver management staff for technical assistance if there is any concern regarding the provider agency's policies and procedures.

Every RRDC and approved TBI provider is responsible for the oversight and reporting of Recordable and Serious Reportable Incidents. This includes, but is not limited to, the reporting, recording, investigation, review and monitoring of incidents. The RRDC notifies NYSDOH of any extraordinary events within 24-hours of receipt of the incident report.

The process for Incident Reporting begins with the occurrence of an 'event', which is defined as an expressed or witnessed occurrence with a potentially negative impact or actual harm to the participant. Once discovered and reported, it is the role of the TBI service provider to evaluate what has occurred, and to determine a proper course of action. This decision may be done with the assistance of the RRDC and/or NYSDOH. The RRDC receives the initial report (24 hours) and reviews it to determine if the incident has been adequately investigated and determines if the incident is closed, or if further investigation is warranted and the investigation must remain open. Within one week of the initial report, the provider agency must submit sufficient follow-up information related to the initial incident.

Any approved TBI provider or an employee of an approved waiver provider who witnesses, discovers or gains knowledge of any action or lack of action that may constitute an incident as described above is responsible for initiating the reporting process. Should it be determined that the matter is a Serious Reportable Incident (SRI), it is the responsibility of the provider who has the most first-hand knowledge (witness) of the incident to complete the Serious Reportable Incident Twenty-Four (24) Hour Report. Some agencies may have internal reporting procedures for incidents and it may not be the initial "reporter" who will notify both the RRDC staff and the Service Coordinator of the incident. If there is a question about whether the event meets the definition of a Serious Reportable Incident, the provider must contact the RRDC to discuss the matter. The Twenty-Four (24) Hour Report serves as initial notification to the RRDC of the incident. Each provider is responsible to initiate the initial review and investigation of the incident which is monitored and reviewed by the RRDC.

The purpose of reporting, investigating, correcting and/or monitoring certain events or situations is to enhance the quality of care provided to participants and to protect them (to the extent possible) from further harm.

If determined a Serious Reportable Incident, the reporting waiver provider must complete the 24-hour Provider Report and send it via fax or encrypted email to the RRDS within twenty-four (24) hours of knowledge/discovery of the incident. At the same time, if the Service Coordination agency is not the reporting waiver provider, a copy of the report must also be faxed or sent via encrypted email by the reporting agency to the Service Coordinator.

The Service Coordinator is responsible for notifying the waiver participant and/or his/her legal guardian within twenty-four (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.

A participant's safety must always be the primary concern of the provider agency, Service Coordinator and the RRDC. Whatever measures appear to be reasonable and prudent to ensure the protection of a person from further harm, injury, or abuse, and to provide prompt treatment or care are taken. When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused a person shall be removed from immediate proximity to, or responsibility for, the participant and may not work with other participants, until the investigation is completed. The RRDS may direct a provider to remove a staff person from the assigned case.

Upon receipt of the 24-hour Provider Report, the RRDS reviews it within forty-eight (48) hours and completes the RRDS Initial Response form, assigning an incident number to the case. The RRDS assigns responsibility for the investigation generally to the provider reporting the incident (investigating waiver provider). If there is concern regarding a potential conflict of interest or appearance of a conflict, the RRDS will assign another waiver provider who provides services to the individual to conduct the investigation. The RRDS and/or Nurse Evaluator will conduct the investigation if the scope of the incident goes beyond one service provider, there is an appearance of conflict of interest among the providers, the provider has demonstrated non-compliance with program manual standards or improper procedures or the NYSDOH requests the RRDC complete the investigation. The RRDS will request technical assistance from the NYSDOH at any time when necessary. When the provider completes the investigation, the report is provided to the RRDC. The RRDC completes the investigation and provides the report to NYSDOH upon request. NYSDOH waiver staff initiates the investigation when a complaint/allegation is made directly to the Department, when the scope of the incident goes beyond the role of the RRDC, the complaint/allegation is about the RRDC or referral or support of outside entities such as OMIG/Attorney General's office is needed. NYSDOH may refer completed investigations to the attention of OMIG/Attorney General's office/Adult Protective Services (APS). If the RRDC determines that the investigation is not sufficient, the RRDC will request additional review/intervention of the incident by the provider and request the investigation be amended or expanded. The RRDS and/or Nurse Evaluator will supplement or complete a separate investigation if he/she determines the provider's investigation is not sufficient and additional review is required. When NYSDOH, the RRDC and/or the provider completes the investigation, a summary of the investigation findings is provided to the complainant. Additional review and response may include NYSDOH, the RRDC and other state protection agencies (Attorney General/OMIG/APS) as appropriate.

At least one individual will be designated by the provider or the RRDC as the "lead investigator" responsible for conducting a thorough and objective investigation of the incident. The investigator must have experience and training in conducting investigations. Those conducting the investigation may not be: directly involved in the incident; an individual providing a statement related to the investigation; or an individual who directly supervises or is related to the "subject" of the investigation. The provider must utilize the statewide investigation format developed by NYSDOH for completing the investigation report.

Every approved TBI provider must have a Serious Incident Review Committee (SIRC) to provide oversight and review of the investigation process and investigation outcomes. The SIRC 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 Committee must review incidents within thirty (30) days of the date of the initial report.

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

Independent HCBS/TBI waiver providers must also form a committee to review serious reportable incidents. One way to accomplish this is to partner with other independent providers or existing agencies.

Within seven (7) calendar days from the date of the RRDS Initial Response, the investigating waiver provider must submit a Provider Follow Up Report to the RRDS and Service Coordinator.

Within thirty (30) days of the initial report made to the RRDC, the investigating provider must complete a Status Report indicating whether the case submitted to the RRDC for investigation remains open. In order for an investigation to be considered closed, the final investigation report must be submitted to the RRDC and the provider's SIRC must have met, reviewed the investigation and indicated that the incident is closed. Upon review of the investigation, the RRDC will send a written notice to the investigating agency and Service Coordinator indicating the incident is considered closed. If it is to remain open, the reasons for that decision must be identified by the RRDS in the notice.

If the investigation remains open, the RRDS provides directions for further investigative action. The RRDS forwards a copy of the RRDS Status Report to the Service Coordinator and the investigating waiver provider. Included in this report will be the anticipated date the investigation will be completed.

No incident investigation may remain open for more than ninety (90) days from the date of the initial report without the expressed approval of the Serious Incident Review Committee, the RRDC and/or NYSDOH. This approval will occur in only the most atypical circumstances, e.g. criminal investigation, civil litigation, etc.

Upon completion of the investigation and completed review by the RRDC, the involved waiver participant receives written notice completed by the investigating provider and/or RRDC informing him/her of the outcome of the investigation. The RRDC must notify the participant within seven (7) calendar days that the investigation has been completed. Although details of the investigation are not disclosed, the final outcome is provided to the participant/legal guardian. Serious Reportable Incidents are not maintained in the participant's file and are not considered to be part of the participant record. Any further contact with the participant will be made at the discretion of the RRDC depending on the outcome of the investigation or consistent with the plan of corrective action or recommendations included in the final investigation report.

A standard investigation format is used by all providers. The format contains a series of questions/issues that must be addressed in the report. The RRDC reviews the report and the supporting document to determine if the investigation process has been sufficient. If the RRDC has a question about the substance of the investigation it will refer the report to NYSDOH for review and guidance. The RRDC returns the investigation report to the provider, requesting additional clarification or information. The investigation is not closed until the RRDC determines it is closed.

Each approved TBI waiver provider must submit a report detailing its Serious Reportable Incidents on a quarterly basis. These reports are submitted to the RRDC for inclusion in a regional report and the regional summary is then submitted to NYSDOH for review and compilation of statewide data and trend analysis.

Each agency's Serious Incident Review Committee must submit an annual report to the RRDC regarding Serious and Recordable incidents, 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, documentation of any changes in the membership during the reporting period and the dates of the committee meetings.

Recordable Incidents are maintained by the approved TBI waiver provider.
Each TBI waiver provider agency has policies and procedures regarding Recordable Incidents to include the following:

The process for reporting, investigating and resolving Recordable Incidents within the agency. This should include the title and name of the individual responsible for the oversight of Recordable Incident reporting for the organization.

The 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.

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

The criteria used to determine when a Recordable Incident should be upgraded to a Serious Reportable Incident.

During survey of waiver providers, NYSDOH evaluates incident processes to assure the waiver providers have complied with all policies/procedures regarding incidents, incident review committees and reporting timeframes. If non-compliance is evident, the waiver provider is issued a statement of deficiencies and must submit a Plan of Correction to NYSDOH.

NYSDOH waiver staff work cooperatively with other state agencies that provide services to individuals with disabilities, informing them when mutual providers experience significant or numerous Serious Reportable Incidents.

Upon request, RRDC staff provides NYSDOH with any additional documentation obtained during an investigation for cases of abuse, neglect, death or any event that is determined to be an SRI.

At any time during the Serious Reportable Incident process, notification to Adult Protective Services (APS) or law enforcement may occur. The State mandates that all Local Department of Social Services (LDSS) offices follow standards for Protective Service for Adults (PSA) as set forth in Section 473 of the Social Services Law, NYCRR 18 -457.1(b), and this policy is communicated to providers in Administrative Directive 90-ADM-40. Referrals are made when a waiver participant's health and welfare appears to be at risk and can be made by anyone, including the participant's family members, RRDC, and/or the Service Coordinator. PSA staff work with other agencies including aging, health, mental health, legal and law enforcement in order to assure a safe plan for the individual. Service Coordination and RRDC staff are encouraged to utilize this resource when a participant is at risk and unable to understand the potential harm and consequences of the situation.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The TBI waiver program ensures participant training and education in a variety of ways.

The waiver applicant first receives information concerning protections and rights when meeting with the RRDS. The RRDS informs the applicant, family and/or legal guardian of the Complaint Line, the philosophy of the waiver and participants' rights and responsibilities and receives contact phone numbers. This information is delineated in the Waiver Participant's Rights and Responsibilities document and the Waiver Contact list. The Waiver Participant's Rights and Responsibilities form is provided to each participant at the time of enrollment. It is also provided annually and any time review of the information is needed.

The Waiver Contact List is provided upon enrollment, reviewed any time there is a new service plan, and updated whenever there is a change in contact information. The Waiver Contact List includes the name, title, phone number and address of all providers as well as information on how to contact RRDC staff and the Complaint Line at the RRDC.

In addition, the Service Coordinator will assist the waiver participant with completing the individualized Plan of Protective Oversight (PPO). The PPO is a document which includes informal supports, protective measures and the emergency back-up plan that is in place to meet the participant's health and welfare needs. The PPO is provided upon enrollment, reviewed with each new service plan, and updated as needed to keep information in the document current.

Service Coordinators are required to meet with participants monthly to review waiver services and discuss any potential issues related to the waiver. A quarterly home visit is required to ensure the safety and comfort of the home environment. Participant safeguards are discussed during these visits.

The RRDSs also meet with participants, their service providers, as well as their family members if applicable. The participants have the opportunity to raise questions or concerns regarding their services, rights and protections during team meetings, which are conducted every six months.

All waiver providers are responsible for protecting and promoting the ability of the participant to exercise all rights identified in the Waiver Participant's Rights form.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The entities that receive reports of critical events or incidents specified in G-1a include the RRDC staff, the SC, the investigating agency and their Serious Incident Review Committee (SIRC). When it is deemed appropriate to contact Protective Services for Adults (APS), or law enforcement as part of the investigation, the RRDC staff will assure this has been done. Any entity involved in the investigation may initiate contact with APS. All contacts with APS and/or law enforcement must be documented as part of the investigation process.

The reporting waiver provider agency provides a copy of the 24-Hour Provider Report to the RRDC within twenty-four (24) business hours if the agency determines that the 'event' is a SRI. The report may be sent via fax or email. A copy of this form is also sent to the SC by the reporting provider agency if the SC agency is not the discoverer.

Within twenty-four (24) business hours of receiving notification that a SRI has occurred, the SC must notify the waiver participant and/or his or her legal guardian that an incident occurred and is being investigated. This contact is documented in the Service Coordination Notification Report and a copy forwarded to the RRDC staff.

The SC notifies other programs or waiver providers whose services are part of the participant's SP and which may be impacted by the incident.

RRDC staff must complete and send a copy of the RRDC Initial Response form to the investigating provider within twenty-four (24) business hours of receiving the 24-Hour Provider Report. Completion of this form includes the incident number assigned to the case by RRDC staff, the provider agency responsible to conduct the investigation, and the due dates of the seven (7) and thirty (30) day follow-up reports required from the investigating provider. If the investigating agency is different from the reporting agency, the RRDC staff will also provide the investigating provider with a copy of the 24-Hour Provider Report. In addition, the RRDC staff will provide a copy of RRDC Initial Response form to the SC.

If the RRDC staff is concerned that the waiver provider deemed responsible for investigating the SRI is not in a position to conduct an objective, thorough investigation, the RRDC staff has the discretion to assign another waiver provider to conduct the investigation.

The investigating waiver provider is responsible for notifying the agency's SIRC 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 documented experience and/or training in conducting investigations. Those conducting the investigation may not be directly involved in the incident (e.g. 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).

Within seven (7) calendar days of receiving the 24-Hour Provider Report and the RRDC Initial Response form (if appropriate), the investigating waiver provider must submit a Provider Follow-Up Report to the RRDC staff with documentation regarding its investigation efforts.

Within seven (7) calendar days of receiving the 7-Day Provider Follow-Up Report, the RRDC staff must review the form and provide written response to the investigating provider regarding as to whether the information received is sufficient to close the incident or requires additional information. The RRDC staff completes and sends the RRDC Status Report to the investigating provider and SC.

If the investigation remains open, the investigating provider must submit a Provider Follow-Up Report within thirty (30) calendar days as designated on the RRDC Initial Response form. A copy of the Provider Follow-Up Report is also provided to the SC by the RRDC staff. Within seven (7) calendar days of receiving the 30-day Provider Follow-Up Report, the RRDC staff makes the decision whether to close the case or leave it open for further investigation. The RRDC staff completes the RRDC Status Report indicating whether the case is closed or remains open. If the case remains open, the reasons why are documented. A copy of the report is sent to the SC and investigating provider by the RRDC staff.

If the incident is considered open for additional investigation beyond the first thirty (30) calendar days, continued follow-up and investigation by the investigating waiver provider is required. For each thirty (30) calendar days that the case remains open, the investigating waiver provider must submit a Provider Follow-Up Report to the RRDC staff each month, based on the date of the first thirty (30) day Provider Follow-Up Report. A copy of each report received is forwarded to the SC by RRDC staff. In each case, the RRDC staff must review the monthly report and provide a completed RRDC Status Report to the investigating provider and the SC within seven (7) calendar days of receiving the monthly report.

Monthly reporting will continue until the RRDC staff determines the investigation can be closed. When this is determined, RRDC staff must complete the RRDC Status Report which Includes of outcomes and of whether the investigation could be substantiated or not. RRDC staff sends a copy of the RRDC Status Report to the investigating provider and to the SC.

RRDC staff may ask NYSDOH waiver staff to provide technical assistance/guidance at any time during the investigation process.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

As a quality measure, the RRDC staff must utilize information obtained from a Serious Reportable Incident (SRI) outcome when reviewing subsequent Service Plans, especially when the SRI investigation results in changes to the Service Plan through an Addendum or Revised Service Plan (RSP) aimed at ensuring the event does not reoccur. The RRDC staff will provide ongoing monitoring of trends and participant status. If negative trends are identified, immediate remediation will be required by the provider agency and monitored by both the RRDC and NYSDOH waiver staff.

Waiver provider agencies must submit reports to the RRDC on a quarterly basis. The reports will contain information regarding all SRI investigations by the agency during the prior quarter and identify trends that might negatively impact participants and remediation efforts (e.g. changes in provider policies or practices).

RRDC staff compare information from SRI investigations and outcomes against participant service plans to assure appropriate follow up and service plan changes, necessary to support the participant's health and welfare, are implemented to prevent reoccurrence. Through analysis of this data, RRDC staff identify agency and regional level trends and direct the providers regarding additional needed remediation activities.

In addition waiver providers submit annual reports to RRDC contractors regarding the activities of the agency in the investigation process, outcomes, and remediation activities. The report provides details on incidents by type, trends identified, and the effectiveness of any changes or improvement in policies and/or practices that occurred during the year. Any discrepancies noted in these reports compared to RRDC data is discussed with the waiver provider agency for corrective action.

Findings from quarterly and annual waiver provider reports are reported by RRDC staff to NYSDOH waiver staff, including recommendations for regional changes/improvements to prevent reoccurrence. Negative trends are discussed by NYSDOH waiver and RRDC staff to determine the need for appropriate remediation. In addition, NYSDOH waiver staff review SRI activities during RRDC site visits. NYSDOH analyzes data from regional SRI trend reports to determine whether any statewide trends are identified. Based on outcomes, NYSDOH waiver staff oversees any remediation activities.

NYSDOH waiver staff complete a comprehensive annual report incorporating data and information from the provider agency and RRDC reports for analysis on a statewide basis.

During surveillance of provider agencies, the DOH Regional Surveillance Unit reviews incident reports maintained by the agency. The review encompasses policy and procedural compliance of the TBI SRI process, review of SRI investigation outcomes, and implementation of corrective and preventive action to reduce or eliminate reoccurrence. Surveillance staff ensure that there is ongoing monitoring of trends and participant status. If negative trends are identified, immediate remediation will be required by the provider agency and monitored by RRDC and NYSDOH waiver staff.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

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

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

The TBI program supports the use of positive approaches which are consistent with standards of professional practice as the preferred method for addressing maladaptive or inappropriate behavior. Individuals with TBI may benefit from specific behavioral interventions. These techniques should emphasize positive approaches in modifying behavior, focus on teaching new behaviors, and provide persons with the skills needed to enhance their everyday functions and quality of life.

Positive Behavioral Interventions and Supports (PBIS) services help staff develop an awareness of the needs of persons with TBI and offer methods for preventing crises or inappropriate behavior.

The use of mechanical devices to manage maladaptive behaviors is prohibited. Use of any restraint is a Serious Reportable Incident (SRI).

Restraint 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 for the expressed purpose of controlling behavior which renders the person unable to satisfactorily participate in services, community inclusion or other activities.

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

Detailed Plans and/or Behavior Plans for PBIS, signed by the participant, are included in service plans for participants receiving this service. These plans contain a functional behavioral analysis, targeted behaviors for remediation, preventative and crisis intervention methods, safeguards, desired outcomes and ongoing assessment strategies. These plans are reviewed and approved by the RRDC on an annual basis or whenever a significant change in the participant’s behavior or health occurs.

Seclusion is prohibited and is considered a form of abuse, and must always be reported as a SRI. Seclusion is defined as the placement of the waiver participant alone in a locked room or area from which he/she cannot leave at will, or from which his/her normal egress is prevented by someone's direct and continuous physical action.

The provider agency providing services at the time the incident occurred or who has first-hand knowledge of this incident is responsible for recording, reporting, and conducting the initial investigation of incident. The RRDC receives initial reports of all incidents.

All instances of use of restraint and seclusion are investigated through the SRI process with necessary action(s) taken by NYSDOH waiver staff, RRDC staff, or both.

If at any time the RRDC discovers deficiencies or issues of concern with regard to these issues and a waiver provider, the RRDC will present the findings to NYSDOH who will obtain reasonable assurances that the agency is capable of delivering services in accordance with the operational standards and the intent of the TBI waiver. If there are questions about the provider’s ability to meet these standards NYSDOH waiver staff will request an additional investigation of the provider.

When the RRDC experiences issues or concerns regarding provider performance, this information will also be relayed to NYSDOH via quarterly reports, emails, and/or by phone. Should a specific provider demonstrate significant problems, NYSDOH may choose to restrict the provider’s services. If the matter is not successfully resolved, NYSDOH waiver staff will determine the appropriate action and may initiate the provider disenrollment process.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. **Use of Restrictive Interventions.** *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

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

NYSDOH is the State agency responsible for overseeing policy compliance regarding the use of restrictive interventions by service providers. NYSDOH in conjunction with the RRDC provides review and oversight of service providers to ensure the safety of participants. These processes are the same as the oversight of incidents related to restraints, seclusion and abuse.

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-b and e.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

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

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

The TBI program supports the use of positive approaches which are consistent with standards of professional practice as the preferred method for addressing maladaptive or inappropriate behavior. Individuals with TBI may benefit from specific behavioral interventions. These techniques should emphasize positive approaches in modifying behavior, focus on teaching new behaviors, and provide persons with the skills needed to enhance their everyday functions and quality of life.

Detailed Plans and/or Behavior Plans for Positive Behavioral Intervention and Supports, signed by the participant, are included in service plans for participants receiving this service. These plans contain a functional behavioral analysis, targeted behaviors for remediation, preventative and crisis intervention methods, safeguards, desired outcomes and ongoing assessment strategies. These plans are reviewed and approved by the RRDC on an annual basis or whenever a significant change in the participant's behavior or health occurs.

Seclusion is prohibited and is considered a form of abuse, and must always be reported as a serious reportable incident. Seclusion is defined as the placement of the waiver participant alone in a locked room or area from which he/she cannot leave at will, or from which his/her normal egress is prevented by someone's direct and continuous physical action.

All instances of use of restraint and seclusion are investigated through the SRI process with necessary action(s) taken by NYSDOH waiver staff, RRDC staff, or both.
The provider agency providing services at the time the incident occurred or who has first hand knowledge of this incident is responsible for recording, reporting, and conducting the initial investigation of incident. The RRDC receives initial reports of all incidents.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

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

a. **Applicability.** Select one:

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

b. **Medication Management and Follow-Up**

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

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

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

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

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

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

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

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

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percentage of participant records that include confirmation of an annual review of the participant's plan of protective oversight, waiver contact list and participant rights and responsibilities (percentage = numerator: number of files audited that contain the PPO, contact list and rights and responsibilities signed by the waiver participant/ denominator: total number of files audited)

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a 5% error margin http://www.raosoft.com/samplesize.html

☑ **Other** Specify: RRDC	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
Each RRDC compiles the regional data garnered from waiver service providers' incident reports and submits an SRI trend report to NYSDOH. This data is reviewed to identify trends throughout the state.

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
The number and percentage of critical incident investigations that were completed within the appropriate timeframes, using the correct investigation format (percentage = numerator: number of critical incident investigations that were completed within the appropriate timeframes using the correct forms/ denominator: total number of critical incident investigations completed)

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
The RRDS have the authority to investigate the conduct, performance and/or alleged neglect of duties of administrators or employees of any agency or individual serving as a HCBS/TBI waiver provider.

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

☑ **Other** Specify: RRDC	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
The number and percantage of allegations of abuse and neglect related to physical restriction or seclusion, investigated and affirmed (percentage = numerator: the number of affirmed abuse and neglect investigations/ denominator: total number of alleged incidents of abuse and neglect)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

☑ **Other** Specify: RRDC	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
The number and percentage of approved services plans that indicate the participant's primary care physician (percentage = numerator: the number of service plans that include the name/address and phone number of the participant's primary care physician/ denominator: total number of approved service plans reviewed)

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. As described in the HCBS/TBI waiver Provider Agreement, the Department and its representative(s) (i.e., the RRDS or others identified as such by the HCBS/TBI waiver staff) have the authority to investigate the conduct, performance and/or alleged neglect of duties of administrators or employees of any agency or individual serving as a HCBS/TBI waiver provider. This level of intervention will occur when there are concerns that the provider has not followed the procedures described in this policy. If the provider is found to be noncompliant with these policies, the State will take appropriate action that may include terminating the Provider Agreement.

NYSDOH 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.

Any employee under investigation for Serious Reportable Incidents by NYSDOH or another State agency is not permitted to provide service to any HCBS/TBI waiver participant until the investigation is completed and the incident is closed.

The RRDC informs NYSDOH waiver staff of issues related to serious incidents and the providers' response to these incidents on an ongoing basis. NYSDOH staff serve as an external monitor to ensure the quality of care provided to participants and to maintain the participants' health and welfare. NYSDOH staff monitor the incident database that tracks incident categories, report responses and incident closures. The RRDC reviews provider quarterly incident reports and identifies trends and outcomes. This information is submitted to NYSDOH waiver staff who compile the data into a statewide analysis. This information assists the NYSDOH to identify trends in incidents within agencies, take corrective measures to minimize the probability of a recurrence of the same or similar situations, and to develop and implement appropriate staff training programs.

The RRDC tracks the status of incidents, reviews all pertinent reports and approves the closure of the investigation. Failure to comply with the investigation and reporting process may result in vendor hold for the provider.

The RRDCs review SIRC meeting minutes for abuse incidents.

NYSDOH conducts on-site surveys of TBI waiver service providers reviewing their policies and procedures for managing Serious Reportable Incidents. According to the TBI Program Manual, the waiver provider must maintain a system for tracking the reporting, investigation and outcome of each incident.

The RRDC reviews the agency SRI and Recordable Incident (RI) policies and procedures during the provider enrollment process to assure they meet the requirements set forth in the TBI Program Manual. The RRDC confirms this to NYSDOH by completing and signing the Waiver Service Provider Interview Form.

RRDC/TBI waiver management staff responsible for the complaint follow-up will contact the complainant to acknowledge receipt of the complaint and to advise that review of the matter is in process.

If the matter is determined to be a Serious Reportable Incident (SRI) by the RRDC, the complaint is reclassified as an SRI and an investigation is initiated by the responsible entity e.g. Service Coordination agency, Service Provider (ILST, CIC). The RRDC sends a letter to the complainant advising him/her of the reclassification of the complaint to an SRI.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
NYSDOH waiver staff review the findings of the RRDC quarterly and annual trend reports which include best practices noted and remedial activities.

RRDC staff conduct meetings and home visits with participants and family members to discuss complaints.

Service providers consistently suspend staff who are involved in an incident of abuse or other situation that presents a risk to the participant pending the outcome of the investigation.

At a Quarterly RRDC meeting, RRDC staff are provided training on Serious Reportable Incidents and

Investigation.

A standardized report format developed by NYSDOH is distributed and utilized by all TBI waiver service providers.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

As the State Medicaid agency, NYSDOH maintains ultimate administrative authority and responsibility for the operation, performance and oversight of all waiver functions by local/regional non-State agencies.

NYSDOH's on-going continuous evaluation of effectiveness of the QIS process is as follows:
• The TBI and MMIS databases offer reports regarding Level of Care, Service Plan development, discharge and transfer data, billing data and provider enrollment.
• RRDC staff complete site visits to providers
• The Office of Primary Care and Health Systems Management (OPCHSM) completes surveys of TBI providers. The survey cycle is every three years.
• Providers are responsible for self-compliance activity as reported to OMIG.
Daily:
• NYSDOH waiver staff maintain contact with the RRDCs, the provider community, waiver participants and stakeholders.
Monthly:
• NYSDOH conducts monthly conference calls with the RRDCs, monitors monthly referral, enrollment and discharge data.
Quarterly:
• NYSDOH meets with the RRDCs to discuss issues and provide training. This includes discussion regarding QI issues and the implementation of new strategies to remedy procedural deficiencies.
• NYSDOH reviews quarterly SRI Trend Reports and Complaint Reports.
• RRDC staff submit quarterly reports identifying and discussing their service deliverables as established in their contracts.
Annually:
• NYSDOH conducts as needed site visits to the RRDCs
• RRDC staff complete an annual self-audit of participant records

• Participant Satisfaction Surveys are conducted by the RRDCs and the findings are submitted to NYSDOH for a statewide analysis.
• NYSDOH completes a comparative review of service plan costs against billing data.
Information garnered from these activities are used to
o Identify issues/areas requiring systemic remediation;
o Remedy statewide deficiencies
o Monitor the efficacy of the changes and amend as needed
o Establish methodology for evaluation of identified systemic remediation.
As Needed:
• NYSDOH will work with the RRDC to resolve participant identified issues;
• NYSDOH monitors all identified participant, providers and stakeholder issues to ensure through resolution.

As the State Medicaid Agency, NYSDOH's primary focus is ensuring that the operation and administration of the TBI waiver adheres to the six waiver assurances.

The RRDS reviews one hundred per cent (100%) of all Initial Service Plans (ISPs) and supporting documentation necessary to support waiver eligibility and reviews/approves all Revised Service Plans and LOC evaluations on an annual basis.

NYSDOH waiver management staff conduct random retrospective reviews, analyzing information and data available on the TBI database and Electronic Medicaid System of New York (eMedNY).

The RRDS reviews one hundred percent (100%) of all LOC assessments for assurance that the participant has been reassessed in a timely manner and continues to meet the required nursing home LOC criteria.

Each RRDC must maintain the NYSDOH database for tracking service plan periods, service plan type (ISP/RSP), LOC assessments, service plan due dates, and type of NOD issued.

RRDCs and waiver service providers assess waiver participant satisfaction regarding their services by conducting annual Participant Satisfaction Surveys.

NYSDOH waiver management staff monitor entries in the TBI database to assure timely development and review of service plans.

Waiver service providers' participant records are reviewed during surveys conducted by NYSDOH OPCHSM.

NYSDOH waiver management staff monitor the number of pending intake, discharges, referrals and service plan reviews completed on a monthly basis.

NYSDOH waiver management staff conduct reviews of service plans against paid claims data acquired through Electronic Medicaid System of New York (eMedNY) to determine if the frequency, type and amount of services claimed and reimbursed were in accordance with the approved service plan.

Comprehensive billing audits may be completed by the OIG and NYS Office of Medicaid Inspector General (OMIG) of waiver service providers. This review includes billing information and supporting documents to compare needed service identification to service utilization.

NYSDOH waiver management staff utilize a provider database system to track information throughout the provider enrollment process as well as maintain critical information that facilitates the survey process.

RRDC conduct at least eight (8) to ten (10) meetings per year to provide updates on waiver policies, procedures and programmatic issues for waiver service providers.

The TBI Program Manual requires that each waiver service provider have policies and procedures in place to protect the health and welfare of the participant prior to approval as a waiver service provider. The NYSDOH OPCHSM reviews these procedures during its surveillance activities of providers.

The RRDC tracks the status of Serious Reportable Incidents, reviews all pertinent reports, determines that the matter has been appropriately addressed and approves the closure of the investigation. If a provider fails to

comply with the investigation and reporting process, NYSDOH may impose a "Vendor Hold" for the provider. As per NYS laws and regulations, NYSDOH has the ability to impose restrictions as needed, including suspension of a waiver service provider's ability to accept new participants and/or termination of a waiver provider's ability to provide TBI waiver services (Vendor Hold).

The RRDC maintains a complaint line and has an established complaint protocol to address issues presented by waiver participants and their advocates. When the RRDC receives a complaint it is forwarded to providers to be addressed or investigated. The RRDC may also conduct independent investigations. All complaints are tracked by the RRDC and monitored by NYSDOH waiver management staff.

Waiver service providers must submit quarterly reports to the RRDC that present all incident data. RRDC staff compile regional data and submit information to NYSDOH waiver management staff. NYSDOH waiver management staff analyze the data for trends, and if needed, NYSDOH waiver management staff make recommendations to the RRDC staff, and/or implement systems changes or enhancements to the waiver program protocols and/or RRDC operations.

A review of a statistically reliable random sample of all active participant files is completed through the RRDC self-audits. This includes verification that the Plan of Protective Oversight (PPO) and Waiver Contact List are contained in the participant's file and updated as required. Findings of the audits are reviewed by NYSDOH waiver management staff.

Oversight of the performance of waiver functions by local/regional non-State agencies is established in statute and regulations that define the respective roles and responsibilities of the State and the Local Department of Social Services (LDSS). See: NYS Public Health Law, Article 2 Title 1 Section 201 and 206, Social Service Law Article 2 Section 20, Article 5 Title 11 Sections 363,363-a, and 363-e

In addition, NYS bulletins, specifically General Information System (GIS) and Medicaid Management Administrative Directives (ADM), are issued to provide ongoing guidance regarding Medicaid program administration, including eligibility determination, system management, provider reimbursement, monitoring, and corrective actions to Local Departments of Social Services.

NYSDOH oversees the RRDC in the fulfillment of their contractual obligations and provides program policy and guidance. This oversight includes but is not limited to: technical assistance, monitoring of the RRDC administration of the program, identification of needed corrective actions, and implementation of those actions. The RRDC responsibilities include: interviewing potential providers in its region and making recommendations for provider enrollment to NYSDOH waiver management staff; review of the LOC assessments to assure all individuals meet LOC criteria; participation in the review and approval of all service plans; review proof of Medicaid eligibility; and assure the participants' health and welfare needs are met.

Additionally, NYSDOH waiver management staff oversee the performance of RRDC contractors through annual retrospective reviews of participant service plans; providing analysis of data generated from participant and provider satisfaction surveys and/or complaints and produce trend reports; conduct RRDC quarterly meetings; review of RRDC quarterly, annual and other pertinent reports; facilitate monthly RRDC conference calls; offer training in fair hearing procedures and decision resolution; establish internal regional policies and procedures, oversee the data base and tracking system development and maintenance; implement provider training and conduct on-site visits with the RRDC staff.

NYSDOH waiver management staff review all fair hearings requests and subsequent dispositions, and give RRDC staff direction on how best to present and resolve the case. They ensure that the action taken by the RRDC can be supported by the evidence and facts of the case. If the actions of the RRDC cannot be supported, NYSDOH waiver management staff recommend a case conference to resolve the matter.

NYSDOH maintains operational control over the waiver service providers through the provider agreement that is signed upon application to become a waiver service provider.

NYSDOH assures that financial oversight and accountability is in place to confirm Medicaid waiver claims are coded and paid in accordance with the approved reimbursement methodology specified in the approved waiver. This is accomplished through a set provider enrollment identification process, a coding system of unique numeric identifiers for each authorized provider and waiver service, and a centralized electronic payment process that is routinely monitored by NYSDOH and audited by NYS Office of the Medicaid Inspector General (OMIG).

The responsibilities of the OMIG include, among other responsibilities, the Medicaid audit function with respect to fraud, waste and abuse. TBI waiver service providers are audited at will by the OMIG. NYSDOH waiver management staff may also recommend waiver providers be audited based upon its concerns or recommendations by RRDC staff. NYSDOH waiver management staff provide additional clarification regarding OMIG interpretation and application of TBI Program Manual standards.

The NYS Attorney General's Office, acting through its Medicaid Fraud Control Unit (MFCU), has the authority to investigate issues of improper Medicaid payments, Medicaid fraud, waste and abuse, and violations of quality of care standards. The Attorney General's Office may institute provider audits and civil proceedings to recover Medicaid overpayments and criminal prosecutions. NYSDOH waiver management staff may provide information and evidence to support these audits.

NYSDOH waiver management staff may compile data received from internal queries, audits of claim detail reports, OMIG and OIG audits. Data is analyzed for regional and statewide trends.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify: RRDC	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The quantitative data generated by NYSDOH waiver management staff, the RRDCs, the Office of Primary Care and Health Systems Management (OPCHSM), and approved TBI service providers includes but is not limited to: Quarterly complaint reports, Quarterly Serious Reportable Incident Reports, RRDC Quarterly Reports, Monthly Data Reports indicating enrollments, discharges, referrals and plan reviews, data garnered from Participant Satisfaction Surveys, retrospective record reviews, site visit findings, observations of training sessions, observation of provider meetings, review of fair hearing dispositions, analysis of ongoing discharges and enrollment trend reports. NYSDOH waiver management staff compile, aggregate data and analyze the findings for statewide trends and service indicators. NYSDOH waiver management staff compare this information to prior years' performance to assess service improvements and/or deficiencies. These findings are reviewed with the RRDCs, NYSDOH management, Provider Alliances, and the TBI Coordinating Council.

NYSDOH uses several approaches for systems improvement. If trend analyses indicate a persistent and pervasive problem the matter is identified for remediation. Issues related to health and welfare take precedent for any targeted improvements. The remedial action may address a specific performance measure or require a system redesign. In both cases, a process to remedy the deficiency is established. A specific time frame to accomplish the remediation activity is established and the responsible person/entity is identified to monitor the implementation of the remedy. Sanctions may be imposed for non-compliance or remediation not incurring in a timely manner.

NYSDOH works collaboratively with stakeholders to identify and quantify the effectiveness of implemented systems design changes. As service providers and participants utilize services their comments and recommendations are considered when exploring system changes.

NYSDOH waiver management staff also collaborate with OPCHSM surveillance staff to monitor newly implemented system design changes that affect service providers. Surveillance findings are shared with NYSDOH waiver staff and disseminated to NYSDOH senior management and RRDC staff to gauge overall effectiveness of waiver operations.

NYSDOH waiver management conduct quarterly RRDC meetings and monthly conference calls to discuss procedural and performance issues. RRDCs are encouraged to provide recommendations for systems change. In turn the RRDCs conduct meetings with service providers eight times a year to discuss protocols, update providers regarding NYSDOH policy and to seek their input and perspective regarding issues related to service delivery and systems improvements.

Results of system change evaluation efforts are communicated to stakeholders, including participants, families, providers, agencies and other interested parties though participation in regional forums, updated information and information posted on the NYSDOH website. A list-serve of TBI service providers is maintained by NYSDOH and is an effective communication tool. The RRDCs and Service Coordinators remain the primary conduit for information to participants. Findings generated from Participant Satisfaction Surveys and comparative analysis of this data over time is an excellent indicator of systems improvements. NYSDOH utilizes the monthly Medicaid Update and the Health Commerce System as its primary communication tool to reach Medicaid providers. NYSDOH maintains a TBI mailbox, where any member of the public or stakeholder can submit questions or provider commentary.

In addition, NYS bulletins, specifically General Information System (GIS) and Medicaid Management Administrative Directives (ADM), may be issued to provide ongoing guidance regarding Medicaid program administration, including eligibility determination, system management, provider reimbursement, monitoring, and corrective actions to Local Departments of Social Services.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Quality improvement (QI) is a continuous process of assessing performance measures, continued sampling and retrospective review. When NYSDOH's ongoing review indicates that there is a problem with consistent non-compliance, or there is a problem in achieving a remedy for a deficiency, then the quality improvement strategy warrants reassessment. Monthly statewide conference calls and Quarterly meetings with the RRDCs are utilized as an open forum to discuss quality improvement actions/projects throughout the year.

NYSDOH is responsible for the design, oversight and implementation of the waiver's quality improvement strategy by providing ongoing program policy guidance and technical assistance; annual monitoring of the RRDC's administration of the program through site visits and case record reviews; identification of necessary corrective actions based on monitoring activities; and monitoring the effectiveness of the remediation activities through follow-up site visit, conference call or case record reviews.
NYSDOH is responsible for ensuring:

• necessary safeguards are in place to ensure the health and welfare of the individuals the waiver serves. This includes the review of incident reports, trend reports,investigations and communication with the RRDCs and providers
• applicants are screened in a timely manner, meet waiver eligibility and are afforded choice of community services vs institutional care;
• service plans reflect the needs of the participant and are developed and implemented according to waiver and NYSDOH policy;
• a sufficient provider base is available for participants to choose as service proividers;
• waiver services continue to be cost effective and do not exceed the cost of institutional care.
• timely submission of annual reports and technical amendments to CMS

On an ongoing basis, NYSDOH waiver management staff review the efficacy of the Quality Management Strategy. Reports and audits are completed on a routine cycle (monthly, quarterly and annual basis). RRDC performance measures are assessed on a quarterly basis. NYSDOH waiver management staff at minimum, conduct a comprehensive review of the Quality Improvement Strategy during the fourth year of the waiver renewal period prior to application for renewal. On an annual basis NYSDOH waiver management staff review audit/assessment findings with the RRDCs including but not limited to: Statewide SRI trends, Annual complaint findings, Statewide Satisfaction Survey findings and Statewide file audits.

NYSDOH waiver management staff has responsibility for coordinating information obtained from ongoing and annual performance measures, as well as input received during the year from the range of parties involved with the TBI waiver (depending on the issue(s) this includes but not be limited to the RRDCs ; participants and their representatives; provider agencies and their representatives; NYSDOH Office of Primary Care and Health Systems Management (OPCHSM) surveillance staff; and the Office of the Medicaid Inspector General. On an annual basis information is reviewed and analyzed using eMedNY reporting systems and other available database information. Findings and recommendations are summarized and assessed. Changes may include: requests for technical amendments to the waiver, revised policies/procedures or forms, Program Manual revisions, and RRDC operational protocols. Based upon specific outcomes from the data NYSDOH waiver management staff make decisions that impact the service delivery system statewide.

NYSDOH and the RRDCs continue to have monthly conference calls and quarterly meetings to include quality monitoring discussions. Topics discussed include findings of reports and trends in the areas of health and welfare, incident management, qualified providers, service plans, fiscal accountability, level of care assurances, as well as any follow up to required remediation and QI strategies.

If review of Monthly Data Reports by NYSDOH waiver management staff reveals delays in eligibility determinations, a high volume of waiver discharges or delays in service plan approvals, then a system failure is identified. If these comparative analyses suggest that remedial activities have not been successful, the systems change process is evaluated and tracked and a new course of action established. Identified outcomes that indicate a need to strengthen/refine the QI process are reported to NYSDOH senior management along with steps, if necessary, for corrective action. Modifications to the program are made as needed.

The TBI waiver's quality improvement strategy is reevaluated at least annually in conjunction with the CMS 372 reporting.

The comprehensive quality improvement strategy may be found in the TBI Waiver Program manual located at the NYS Department of Health website.

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).

NYSDOH is the single State agency responsible for monitoring payments made under the New York State Medicaid program. Statewide audits of Medicaid funded programs are conducted by the Office of the State Comptroller (OSC), the Office of the Attorney General (AG), the Department of Health, and the Office of the Medicaid Inspector General (OMIG). In addition, the operating agency and local counties also conduct reviews and audits of Medicaid funded programs.

Annual Cost Reporting and Auditing

Cost reporting for waiver services will be subject to review. The Cost report will be submitted to CMS within 16 months after the close of the reporting period.

Delinquent Cost Reporting for Non-State Providers

If a provider has not filed a complete and compliant annual Certified Cost Report (CCR) for any CCR reporting period, the provider will be considered delinquent. The State will not claim FFP for any waiver services provided by a delinquent provider.

For CCR cost reporting beginning January 1, 2018 and thereafter, Non-State (NS) providers are required to file an annual CCR to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period. Providers are not required to secure an independent financial audit. If a NS provider fails to file a complete and compliant CCR within 60 days following the imposition of the 2% penalty, the State must provide timely notice to the delinquent provider that FFP will end 240 days following the imposition of the 2% penalty; and the State will not claim

FFP for any waiver services provided by the NS provider with a date of service after the 240 day period. An accounts receivable is set up to recoup any inappropriate billings to recover the funds from the provider over time. The state does not claim any FFP above the net adjusted amount when filing claims for FFP.

Oversight of Service Delivery and Billings and Claims:

Each year in January, NYSDOH will establish an audit pool that includes all waiver service providers with waiver service billings. Paid claims will be audited for the period of October 1 to September 30 of the previous year to ensure that providers are appropriately billing for authorized services, correct reimbursement rates/fees, and for the correct number of units of service. NYSDOH conducts an annual review of less than 100% of records of individuals actively enrolled in the TBI waiver at the time of audit using a statistically reliable sample with a 95% confidence interval and a 5% margin of error using Raosoft formulas.

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

Any systemic deficiencies will be identified and a plan of correction developed which may result in the following: new directives to providers, procedural remedy, specific vendor intervention (vendor hold and/or termination), or amendment to the waiver application. Improperly paid claims will be reimbursed to the state and FFP will be returned to CMS.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability Assurance:**
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**

      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

      Performance Measures

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

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

      Performance Measure:
      Number and percent of file reviews of billed and paid services that are consistent with the approved hours of services in the participant's service plan. (Percent = numerator: number of file reviews in which billed and paid services are consistent with the approved hours of service in participants service plan/ denominator: total number of file reviews)

      Data Source (Select one):
      Record reviews, off-site

If 'Other' is selected, specify:
Participant specific reports from the Data Warehouse of billed services for the period of time indicated by the approved service plan.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% of statewide enrollment
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Providers will identify provider costs in accordance with Generally Accepted Accounting Principles (GAAP) using the certified cost reporting system, a standardized reporting method.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. NYSDOH waiver management staff compare billed services to the service plan. Any case that presents a 20% deviation (above or under) the projected cost of services in the service plan is identified for additional review.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The remediation process is initiated when the Regional Resource Development Specialist (RRDS) or NYSDOH waiver management staff identifies a lack in the quality of provided services, or any other significant issue related to administration of TBI.

Remediation of financial issues begins immediately upon the discovery of any impropriety. NYSDOH waiver management staff, and other Department staff such as staff within the Fiscal Management Group (FMG), Provider enrollment and others, as appropriate, immediately initiate remediation of any inappropriate claims processed through eMedNY. Remediation may include voiding payments, adjusting paid claims, assigning penalties, and sanctioning providers through collaboration with OMIG and the Attorney General.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide TBI services. In such circumstances, NYSDOH waiver management staff will issue a letter to the provider terminating the provider's TBI waiver provider status.

Documentation of remediation activities is accomplished by the following measures: correspondence among NYSDOH waiver management staff, the RRDC, participants and their parents/legal guardians, and/or service providers; amended plans of care; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file and, as appropriate, by NYSDOH/DLTC.

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

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

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The TBI waiver will transition to managed care programs effective January 1, 2019. This fee schedule expense reimbursement covers claims effective for dates of service beginning with the approval of the waiver application through the transition to managed care.

Provider Reimbursement of Waiver Services

TBI HCBS services are provided by Non-State Government and Private provider agencies and sole proprietors. Private provider agencies are nonprofit organizations, for-profit organizations or proprietary agencies. The New York State (NYS) renewal application seeks to renew the 1915(c) Home and Community Based Medicaid (MA) waiver, Traumatic Brain Injury (TBI), to extend it effective the approval date of the waiver through December 31, 2018; after which, the waiver will transition into managed care programs on January 1, 2019. The Cost report will be submitted to CMS within 16 months after the close of the reporting period.

The rates for Service Coordination, Community Integration Counseling, Home and Community Support Services, Independent Living Skills Training, Positive Behavioral Interventions and Supports, Respite Services and Structured Day Program were derived from rates in effect during the previous waiver application period. The rates for Assistive Technology, Community Transitional Services, Environmental Modification Services are based on actual costs.

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. All approved TBI service providers receive notice of the rates for their approved services at the time of provider enrollment.

NYSDOH gives public notice required by the State Administrative Procedure Act (SAPA) and other State Laws of any amendment to its regulations regarding the rate-setting methodology. SAPA requires that a Notice of Proposed Rulemaking include a name, public office address and telephone number for an agency representative to whom written views and arguments may be submitted.

I. Definitions Applicable to this Section

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

NYSDOH has assigned separate rate codes for amount of dollars for each of these services to track the amount/cost of each service that is provided. This allows the waiver provider to bill, through the eMedNY system, the specific number of units which reflects the cost for these services.

Transportation costs reflect non-medical trips captured by the service coordinators and transportation contractors for TBI waiver participants, through the New York State Department of Health's contracted transportation system.

TBI Regions: There are waiver service regions designated by NYSDOH throughout the state. Each provider must seek approval to provide services in each designated region. Services are provided as reported on the certified cost report. Fee schedules are based on the following geographic indicators:

• Downstate: The five boroughs of New York City (New York, Kings, Queens, Richmond, Bronx Counties) and the Counties of Nassau, Suffolk, Rockland, and Westchester.

• Upstate: All other counties of the state that are not included in the downstate region.

The unit of measure used for the following waiver services are:
• Service Coordination – Initial and Monthly
• Assistive Technology – Per Occurrence
• Community Integration Counseling - Hourly
• Community Transitional Services – Per Occurrence
• Environmental Modification – Per Occurrence
• Home and Community Supports – Hourly
• Independent Living Skills - Hourly
• Positive Behavioral Interventions and Supports – Hourly
• Respite, In Home - Per diem (24 hour block of time)
• Structured Day Programs – Hourly
• Substance Abuse Program - Hourly
• Waiver Transportation (per trip)

II. Reporting Requirements

a. The Non-State Government Providers and Private Providers shall identify provider costs in accordance with Generally Accepted Accounting Principles (GAAP.)

b. Using a standard reporting tool, a process will be implemented on January 1, 2018 for cost reporting. These cost reports will be used to reconcile the Medicaid payments for waivers. The process will demonstrate that NYS' costs are economic and efficient. When the providers governed under this 1915(c) waiver have migrated to managed care, NYS will review the reconciliation and allow providers who under spent to keep the money under a Value Based Payment arrangement. This will allow a smooth transition without disruption to services.

The Cost Reporting schedules to be completed annually are:

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

III. Services Paid via Fee Schedule: Statewide Rates for All providers (average upstate and downstate)
1. Service Coordination Initial $618.69
2. Service Coordination Monthly $453.02
3. Assistive Technology – Per Occurrence
4. Community Integration Counseling - Hourly $82.84
5. Community Transitional Services – Per Occurrence
6. Environmental Modification – Per Occurrence
7. Home and Community Supports – Hourly $22.88
8. Independent Living Skills - Hourly $41.42
9. Positive Behavioral Interventions and Supports – Hourly $62.13
10.Respite, In Home - Per diem (24 hour block of time) $334.37
11.Structured Day Programs – Hourly $20.20
13.Substance Abuse Program - Hourly $34.00
14. Waiver Transportation (per trip)

Cost reporting for non-profit waiver services will be subject to review. The Cost report will be submitted to CMS within 16 months after the close of the reporting period. The use of retrospective reimbursement, using service provider cost requires a reconciliation of any and all interim payments to the final allowable Medicaid cost for each rate year. FFP would be limited to the actual cost of the service(s) at the service provider level, or if reimbursement payments to the service provider were less and/or ultimately less than actual cost, FFP would be limited to the lower of these to actual cost or actual payments. If such total payments for any Waiver Service, subject to the annual reconciliation, exceed the final allowable Medicaid reimbursement for such rate period, the State will treat any overage as an overpayment of the federal share, and any overpayment shall be returned to CMS on the next calendar quarter CMS-64 expenditure report. If the total payments for a Waiver Service, subject to annual reconciliation, are less than the allowable Medicaid reimbursement for such rate period, the State shall be entitled to submit a claim for the federal share of such difference.

IV. Services paid using a Contract Amount

a. Waiver Transportation
Transportation costs reflect non-medical trips captured by the service coordinators and transportation contractors for TBI waiver participants, through the New York State Department of Health's contracted transportation system.

V. Trend Factors

a.The trend factor used will be the applicable years from the Medical Care Services Index for the period April to April of each year from www.bls.gov/cpi; Table 1 Consumer Price Index for All Urban Consumers (CPI-U); U.S. city average, by expenditure category and commodity and service group.

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 New York State Medicaid Management Information System (MMIS), Electronic Medicaid System of New York (eMedNY) system is a computerized system for claims processing. The eMedNY design is based on the recognition that Medicaid processing can be highly automated and that provider relations and claims resolution require an interface with experienced program knowledgeable people. This approach results in great economies through automation, yet eliminates the frustration that providers frequently encounter in dealing with computerized systems.

The provider enrollment application includes a series of forms, and a signature and affirmation section that the provider signs and agrees to comply with all Medicaid rules, regulations and official directives. Furthermore, to submit claims, the provider must obtain the Electronic/Paper Transmitter Identification Number and submit a notarized certification

statement. The statement is renewed annually by the provider. Failure to renew the statement results in denial of the provider's claims by the eMedNY system.

Each waiver provider is assigned a provider identification number in eMedNY, which is dedicated solely to the TBI waiver and assures only enrolled waiver providers can bill for services. Each waiver service is assigned a unique rate code.

Providers must verify Medicaid eligibility prior to provision of services and obtain authorization for specific services. A participant must present an official Common Benefit Identification Card (CBIC) to the provider when requesting services. The issuance of an Identification Card does not constitute full authorization for provision of medical services and supplies. The participant's eligibility must be verified through eMedNY to confirm the participant's eligibility for services and supplies. A provider not verifying eligibility prior to provision of services will risk the possibility of nonpayment for those services.

The Medicaid provider is responsible for ensuring the accuracy of appropriate Medicaid data, such as the Medicaid provider ID, Medicaid recipient ID, date of service, that the service was provided to an approved waiver participant and the rate code for the services provided. The eMedNY system adjudicates the claim and reimbursement is issued directly to the provider.

All Medicaid claims submitted to eMedNY are subject to a series of edits to ensure validation of data, including waiver participant Medicaid eligibility; enrollment of the service recipient in the waiver on the date of service; and enrollment of the waiver service provider at the time of service. Claims submitted after two (2) years from the date of service will be rejected.

Financial accountability is built into the fiscal and claiming process with systems controls and edits developed to enforce proper claiming activity. The claims process is the same used for all Medicaid claims. The claims for TBI waiver services are submitted by the agencies enrolled as providers through the eMedNY system for payment. Electronic system controls allow only TBI enrolled Medicaid providers to be paid for claims for TBI services on TBI participants as identified by the R/E Code 81. All providers must maintain records that adequately support all billing for waiver services.

Appendix I: Financial Accountability

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

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

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

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

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Claims for all HCBS waiver services are adjudicated by eMedNY. The eMedNY system identifies HCBS enrollees with codes (Restriction/Exemption/RE) that identify the person as HCBS enrolled and the effective date of the enrollment. Payment system edits require the client record to indicate active Medicaid eligibility and HCBS Waiver enrollment for all dates of service billed. All billings are processed either through eMedNY or through direct payment to the transportation contractors through the NYSDOH contracted transportation system.

Claims for federal financial participation (FFP) 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 with the approved waiver. FFP claims for these waiver services are subject to the same policies and procedures that the NYSDOH Office of Health Insurance Programs (OHIP) through the eMedNY system uses to claim federal financial participation for all other Medicaid services.

Providers must verify Medicaid eligibility prior to provision of services and obtain authorization for specific services. A provider not verifying eligibility prior to provision of services will risk the possibility of nonpayment for those services.

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; and whether the service providers are enrolled as waiver service providers in New York State. The edits also ensure that a participant is eligible for waiver services and verifies that the participant was eligible on the date the service was provided. In addition, all waiver claims paid through eMedNY are subject to all the common payment integrity edit tests, as well as those specific to waiver transactions.

NYSDOH waiver staff conduct a random retrospective record audit annually This review focuses on whether the services provided were part of the approved service plan and whether the amount of services was prior approved. NYSDOH waiver staff run queries to review participant service plans and compare them with claims data from the eMedNY system. The billing queries run on the same dates as the approved service plans. Each service plan contains a projected cost of services. A comparison of the projected costs to the billed claims is completed. Any service plan with a deviation of twenty percent (20%) above or below the projected cost to the billed amount is set aside for additional review and follow-up by the RRDC.

To ensure that claims 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; 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 goals that are being worked on and the participant’s progress toward attaining those goals.

Upon completion of each OMIG audit, final reports are written disclosing deficiencies pertaining to claiming, record keeping and provision of service. These final audit reports are sent to the waiver provider and are available on the OMIG website for routine review by NYSDOH waiver management staff.

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

In the Participant Satisfaction Survey, participants are asked about their experiences with the services that they have received. Responses to the Survey are provided to the RRDC and NYSDOH waiver staff. NYSDOH waiver staff follow up on areas of concerns if the response suggests that a participant did not receive services identified in their service plan. RRDSs also make home visits to waiver participants to discuss service delivery issues.

To ensure providers of Environmental Modifications (E-mods), Assistive Technology (AT), and Community Transitional Services (CTS) are billing properly, providers are required to submit projected cost estimates and final cost reports to the Service Coordinator. Each specific payment is made based on the tasks performed or the equipment or parts purchased on behalf of the participant. These reports are provided to the RRDC for approval. Payment reports for these services are reviewed by NYSDOH and the RRDC annually to ensure the billed amount is the same as the amount approved. If there is a difference between the projected and actual costs, the RRDC requires an Addendum to the Service Plan to justify the increase.

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. Upon approval of the application, NYSDOH waiver staff will issue further billing direction to providers and RRDCs in its Program Manual and will develop more detailed billing guidelines for posting on the eMedNY Provider manual site: https://www.emedny.org/ProviderManuals/HCBS-TBIWaiver/index.aspx

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ◉ **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

  Social Transportation:
  The Department of Health (DOH) has contracted with professional transportation management entities to manage transportation on behalf of Medicaid enrollees, including TBI waiver participants.

  DOH-contracted transportation managers have no vehicles and do not provide transportation in competition with existing Medicaid-enrolled transportation vendors. There are no additional requirements for Medicaid-enrolled transportation vendors to participate with the contracted transportation manager. Transportation vendors do not need to contract with the transportation manager or complete a new Medicaid enrollment application to receive trip assignments. Rather, the manager will use all existing transportation vendors to the extent possible in accordance with contractual obligations.

  There is no rate code assigned to Waiver Transportation, therefore, it cannot be specifically tracked through eMedNY. Billing for non-medical transportation is identified and tracked by the Contracted Transportation Manager and reported to waiver management staff for required reporting.
  See: https://www.emedny.org/ProviderManuals/Transportation/PDFS/Transportation_Manual_Policy_Section.pdf
- ○ **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

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

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

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ○ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ◉ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

Any agency that qualifies as governmental such as 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.**
- ○ **This waiver is a part of a concurrent □1115/□1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The □1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [x] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The General Fund (state tax revenue supported) state share for Medicaid is also appropriated in the NYS Office of Mental Health (OMH), Office of People with Developmental Disabilities (OPWDD), 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)].

- [x] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

In addition to the State's General Fund-Local Assistance Account appropriation, NYSDOH has two HCRA Resources Fund appropriated accounts (the Indigent Care Account and the Medical Assistance Account) and a Miscellaneous Special Revenue Fund appropriation (Medical Assistance Account) that fund the state share of Medicaid. The HCRA accounts are funded with HCRA revenues as specified in sections 2807-k, 2807-w, 2807-v, and 2807-l of the NYS Public Health Law. Revenue for the Medical Assistance Account results from assessments on the gross cash receipts of nursing homes, hospitals, certified home health agencies, long term home health care providers and personal care providers (as specified in sections 2807-d, 3614-a and 3614-b of the NYS Public Health Law and section 367-i of the Social Services Law.) In addition, the Local Assistance Account receives a refund of appropriation from drug rebates, audit recoveries and refunds, and third party recoveries.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- ( ) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- (•) **Applicable**

Check each that applies:

- [x] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Counties in New York State and the City of New York have the authority to levy taxes and other revenues. These local entities may raise revenue in a variety of ways including taxes, surcharges and user fees. The State, through a state/county agreement, has an established system by which local entities are notified at

regular intervals of the local share of Medicaid expenditures for those individuals for which they are fiscally responsible. In turn, the local entities remit payment of these expenditures directly to the State.

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

◉ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

○ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ **Nominal deductible**
☐ **Coinsurance**
☐ **Co-Payment**
☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: 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	49557.26	17107.00	66664.26	80828.00	8555.00	89383.00	22718.74
2	49863.47	17449.00	67312.47	82444.00	8726.00	91170.00	23857.53
3	50194.23	17798.00	67992.23	84092.00	8901.00	92993.00	25000.77
4	51104.77	18154.00	69258.77	85773.00	9079.00	94852.00	25593.23
5	51259.46	18517.00	69776.46	87488.00	9260.00	96748.00	26971.54

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	**3615**		3615
Year 2	**3940**		3940
Year 3	**4294**		4294
Year 4	**4680**		4680
Year 5	**5132**		5132

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 submitted 372 reports. Since no significant additional capacity nor any participant flow variation 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 333.

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 four (4) year average reported on the most recent 372s through 2013 for the number of users by service and average units per participant. Average annual unit costs were projected for Upstate and Downstate NY due to the rate differential. The Medicaid Redesign Team Initiatives provide for a "global cap" for state share Medicaid spending over the next five (5) years. The TBI Waiver Program is implementing a cost reporting process to begin in January 2018. As such, projected rate differentials are not reflected for the five year waiver period. In the future, cost reporting data will be used to analyze and adjust rates. Additionally, NYSDOH participates in the Money Follows the Person initiative impacting the cost of services directly related to those individuals transitioning from nursing facilities. This program participation has been calculated into the number of users for transitional services such as CTS.

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 four (4) year average reported on the most recent 372s through 2013 in aggregate. The annual growth of 2% used to trend forward Factor D' is based on the average 2014-15 average consumer price index (CPI) for medical care services from the U.S. Bureau of Labor statistics and the trend data reflected in the 372 reporting.

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. Individuals residing in nursing facilities were identified by using two particular fields of the MDS assessment tool. These recipient IDs were used in the cost extract program for institutional populations. Data garnered from this search was cross referenced to the reported costs presented in the four (4) year average reported on the most recent 372 reports through 2013 in aggregate. The same trend ratio as utilized for growth in the D factors was applied for projected G factors.

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. Individuals residing in nursing facilities were identified by using two particular fields of the MDS assessment tool. These recipient IDs were used in the cost extract program for institutional populations. Data garnered from this search was cross referenced to the reported costs presented in the four (4) year average reported on the most recent final 372 reports through 2013 in aggregate. The same trend ratio as utilized growth in Factor D' was applied for projected G' factors.

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	
Respite	
Service Coordination	
Assistive Technology Services (AT)	
Community Transitional Services (CTS)	
Environmental Modifications Services	
Transportation Services	
Community Integration Counseling (CIC)	
Home and Community Support Services (HCSS)	
Independent Living Skills and Training Services	
Positive Behavioral Interventions and Support Services	
Structured Day Program Services (SDP)	
Substance Abuse Program Services	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932 (a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**23405.90**
Respite						**23405.90**	
					GRAND TOTAL:		**179149506.24**
					Total: Services included in capitation:		40649815.90
					Total: Services not included in capitation:		138499690.34
					Total Estimated Unduplicated Participants:		**3615**
					Factor D (Divide total by number of participants):		**49557.26**
					Services included in capitation:		11244.76
					Services not included in capitation:		38312.50
					Average Length of Stay on the Waiver:		333

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	☑	24 hours	5	14.00	334.37		
Service Coordination Total:							**18260354.34**
Service Coordination- Initial	☐	per admission	290	1.00	618.69	**179420.10**	
Service Coordination- Monthly	☐	monthly	3326	12.00	453.02	**18080934.24**	
Assistive Technology Services (AT) Total:							**5090400.00**
Assistive Technology Services (AT)	☑	hour	480	525.00	20.20	**5090400.00**	
Community Transitional Services (CTS) Total:							**48000.00**
Community Transitional Services (CTS)	☑	per NF discharge	6	1.00	8000.00	**48000.00**	
Environmental Modifications Services Total:							**600000.00**
Environmental Modifications Services	☑	per modification	50	1.00	12000.00	**600000.00**	
Transportation Services Total:							**5096000.00**
Transportation Services	☐	per person per year	980	1.00	5200.00	**5096000.00**	
Community Integration Counseling (CIC) Total:							**6217142.00**
Community Integration Counseling (CIC)	☑	hour	1501	50.00	82.84	**6217142.00**	
Home and Community Support Services (HCSS) Total:							**115143336.00**
Home and Community Support Services (HCSS)	☐	hour	2200	2254.00	23.22	**115143336.00**	
Independent Living Skills and Training Services Total:							**12084699.20**
Independent Living Skills and Training Services	☑	hour	2084	140.00	41.42	**12084699.20**	
Positive Behavioral Interventions and Support Services Total:							**4272058.80**
Positive Behavioral Interventions and Support Services	☑	hour	573	120.00	62.13	**4272058.80**	
Structured Day Program Services (SDP) Total:							**11453400.00**
Structured Day Program Services (SDP)	☑	hour				**11453400.00**	

GRAND TOTAL:	**179149506.24**
Total: Services included in capitation:	40649815.90
Total: Services not included in capitation:	138499690.34
Total Estimated Unduplicated Participants:	**3615**
Factor D (Divide total by number of participants):	**49557.26**
Services included in capitation:	11244.76
Services not included in capitation:	38312.50
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			1080	525.00	20.20		
Substance Abuse Program Services Total:							**860710.00**
Substance Abuse Program Services	☑	hour	61	415.00	34.00	**860710.00**	

GRAND TOTAL:	**179149506.24**
Total: Services included in capitation:	40649815.90
Total: Services not included in capitation:	138499690.34
Total Estimated Unduplicated Participants:	**3615**
Factor D (Divide total by number of participants):	**49557.26**
Services included in capitation:	11244.76
Services not included in capitation:	38312.50
Average Length of Stay on the Waiver:	333

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932 (a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**28087.08**
Respite	☑	24 hours	6	14.00	334.37	**28087.08**	
Service Coordination Total:							**19910537.70**
Service Coordination- Initial	☐	upon admission	330	1.00	618.69	**204167.70**	
Service Coordination- Monthly	☐	monthly	3625	12.00	453.02	**19706370.00**	
Assistive Technology Services (AT) Total:							**709114.86**
Assistive Technology Services (AT)	☑	per unit	542	1.00	1308.33	**709114.86**	
Community Transitional Services (CTS) Total:							**56000.00**
Community Transitional Services (CTS)	☑	per unit	7	1.00	8000.00	**56000.00**	

GRAND TOTAL:	**196462079.48**
Total: Services included in capitation:	40845385.74
Total: Services not included in capitation:	155616693.74
Total Estimated Unduplicated Participants:	**3940**
Factor D (Divide total by number of participants):	**49863.47**
Services included in capitation:	10366.85
Services not included in capitation:	39496.62
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications Services Total:							**672000.00**
Environmental Modifications Services	☑	per modification	56	1.00	12000.00	**672000.00**	
Transportation Services Total:							**5751200.00**
Transportation Services	☐	per person per year	1106	1.00	5200.00	**5751200.00**	
Community Integration Counseling (CIC) Total:							**7016548.00**
Community Integration Counseling (CIC)	☑	hour	1694	50.00	82.84	**7016548.00**	
Home and Community Support Services (HCSS) Total:							**129954956.04**
Home and Community Support Services (HCSS)	☐	hour	2483	2254.00	23.22	**129954956.04**	
Independent Living Skills and Training Services Total:							**13638777.60**
Independent Living Skills and Training Services	☑	hour	2352	140.00	41.42	**13638777.60**	
Positive Behavioral Interventions and Support Services Total:							**4823773.20**
Positive Behavioral Interventions and Support Services	☑	hour	647	120.00	62.13	**4823773.20**	
Structured Day Program Services (SDP) Total:							**12927495.00**
Structured Day Program Services (SDP)	☑	hour	1219	525.00	20.20	**12927495.00**	
Substance Abuse Program Services Total:							**973590.00**
Substance Abuse Program Services	☑	hour	69	415.00	34.00	**973590.00**	

GRAND TOTAL:	**196462079.48**
Total: Services included in capitation:	40845385.74
Total: Services not included in capitation:	155616693.74
Total Estimated Unduplicated Participants:	**3940**
Factor D (Divide total by number of participants):	**49863.47**
Services included in capitation:	10366.85
Services not included in capitation:	39496.62
Average Length of Stay on the Waiver:	333

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932 (a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs

fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**28087.08**
Respite	✓	24 hours	6	14.00	334.37	**28087.08**	
Service Coordination Total:							**21695876.40**
Service Coordination- Initial		per admission/avg u	360	1.00	618.69	**222728.40**	
Service Coordination- Monthly		month/avg up/down	3950	12.00	453.02	**21473148.00**	
Assistive Technology Services (AT) Total:							**778456.35**
Assistive Technology Services (AT)	✓	per unit	595	1.00	1308.33	**778456.35**	
Community Transitional Services (CTS) Total:							**64000.00**
Community Transitional Services (CTS)	✓	per NF discharge	8	1.00	8000.00	**64000.00**	
Environmental Modifications Services Total:							**744000.00**
Environmental Modifications Services	✓	per modification	62	1.00	12000.00	**744000.00**	
Transportation Services Total:							**6312800.00**
Transportation Services		per person per year	1214	1.00	5200.00	**6312800.00**	
Community Integration Counseling (CIC) Total:							**7704120.00**
Community Integration Counseling (CIC)	✓	houravg up/downsta	1860	50.00	82.84	**7704120.00**	
Home and Community Support Services (HCSS) Total:							**142673060.88**
Home and Community Support Services (HCSS)		houravg up/downsta	2726	2254.00	23.22	**142673060.88**	
Independent Living Skills and Training Services Total:							**14978300.40**
Independent Living Skills and Training Services	✓	houravg up/downsta	2583	140.00	41.42	**14978300.40**	
Positive Behavioral Interventions and Support Services Total:							**5293476.00**

GRAND TOTAL:	**215534027.11**
Total: Services included in capitation:	44852289.83
Total: Services not included in capitation:	170681737.28
Total Estimated Unduplicated Participants:	**4294**
Factor D (Divide total by number of participants):	**50194.23**
Services included in capitation:	10445.34
Services not included in capitation:	39748.89
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Positive Behavioral Interventions and Support Services	✓	houravg up/downsta	710	120.00	62.13	5293476.00	
Structured Day Program Services (SDP) Total:							14189490.00
Structured Day Program Services (SDP)	✓	hour/avg up/downsta	1338	525.00	20.20	14189490.00	
Substance Abuse Program Services Total:							1072360.00
Substance Abuse Program Services	✓	hour	76	415.00	34.00	1072360.00	
					GRAND TOTAL:		215534027.11
					Total: Services included in capitation:		44852289.83
					Total: Services not included in capitation:		170681737.28
					Total Estimated Unduplicated Participants:		4294
					Factor D (Divide total by number of participants):		50194.23
					Services included in capitation:		10445.34
					Services not included in capitation:		39748.89
					Average Length of Stay on the Waiver:		333

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932 (a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							32768.26
Respite	✓	24 hours	7	14.00	334.37	32768.26	
Service Coordination Total:							23654688.06
Service Coordination- Initial		upon admission/avg	398	1.00	618.69	246238.62	
Service Coordination- Monthly		monthavg up/downs	4306	12.00	453.02	23408449.44	
Assistive Technology Services (AT) Total:							864806.13
Assistive Technology Services (AT)	✓					864806.13	
					GRAND TOTAL:		239170335.93
					Total: Services included in capitation:		49859533.59
					Total: Services not included in capitation:		189310802.34
					Total Estimated Unduplicated Participants:		4680
					Factor D (Divide total by number of participants):		51104.77
					Services included in capitation:		10653.75
					Services not included in capitation:		40451.03
					Average Length of Stay on the Waiver:		333

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		per unit	661	1.00	1308.33		
Community Transitional Services (CTS) Total:							**72000.00**
Community Transitional Services (CTS)	✓	per unit cap	9	1.00	8000.00	**72000.00**	
Environmental Modifications Services Total:							**828000.00**
Environmental Modifications Services	✓	per modification	69	1.00	12000.00	**828000.00**	
Transportation Services Total:							**7020000.00**
Transportation Services		per person per year	1350	1.00	5200.00	**7020000.00**	
Community Integration Counseling (CIC) Total:							**8565656.00**
Community Integration Counseling (CIC)	✓	houravg up/downsta	2068	50.00	82.84	**8565656.00**	
Home and Community Support Services (HCSS) Total:							**158636114.28**
Home and Community Support Services (HCSS)		houravg up/downsta	3031	2254.00	23.22	**158636114.28**	
Independent Living Skills and Training Services Total:							**16648354.80**
Independent Living Skills and Training Services	✓	houravg up/downsta	2871	140.00	41.42	**16648354.80**	
Positive Behavioral Interventions and Support Services Total:							**5882468.40**
Positive Behavioral Interventions and Support Services	✓	houravg up/downsta	789	120.00	62.13	**5882468.40**	
Structured Day Program Services (SDP) Total:							**15780240.00**
Structured Day Program Services (SDP)	✓	houravg up/downsta	1488	525.00	20.20	**15780240.00**	
Substance Abuse Program Services Total:							**1185240.00**
Substance Abuse Program Services	✓	houravg up/downsta	84	415.00	34.00	**1185240.00**	

GRAND TOTAL:	**239170335.93**
Total: Services included in capitation:	49859533.59
Total: Services not included in capitation:	189310802.34
Total Estimated Unduplicated Participants:	**4680**
Factor D (Divide total by number of participants):	**51104.77**
Services included in capitation:	10653.75
Services not included in capitation:	40451.03
Average Length of Stay on the Waiver:	333

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932 (a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**37449.44**
Respite	☑	24 hours	8	14.00	334.37	**37449.44**	
Service Coordination Total:							**25936712.64**
Service Coordination- Initial	☐	upon admission	440	1.00	618.69	**272223.60**	
Service Coordination- Monthly	☐	monthavg up/downs	4721	12.00	453.02	**25664489.04**	
Assistive Technology Services (AT) Total:							**952464.24**
Assistive Technology Services (AT)	☑	per unit	728	1.00	1308.33	**952464.24**	
Community Transitional Services (CTS) Total:							**72000.00**
Community Transitional Services (CTS)	☑	per NF discharge	9	1.00	8000.00	**72000.00**	
Environmental Modifications Services Total:							**912000.00**
Environmental Modifications Services	☑	per modification	76	1.00	12000.00	**912000.00**	
Transportation Services Total:							**7727200.00**
Transportation Services	☐	per person per year	1486	1.00	5200.00	**7727200.00**	
Community Integration Counseling (CIC) Total:							**9423050.00**
Community Integration Counseling (CIC)	☑	houravg up/downsta	2275	50.00	82.84	**9423050.00**	
Home and Community Support Services (HCSS) Total:							**174546829.80**
Home and Community Support Services (HCSS)	☐	houravg up/downsta	3335	2254.00	23.22	**174546829.80**	
							18318409.20

GRAND TOTAL:	**263063536.72**
Total: Services included in capitation:	54852794.28
Total: Services not included in capitation:	208210742.44
Total Estimated Unduplicated Participants:	**5132**
Factor D (Divide total by number of participants):	**51259.46**
Services included in capitation:	10688.39
Services not included in capitation:	40571.07
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living Skills and Training Services Total:							
Independent Living Skills and Training Services	✓	houravg up/downsta	3159	140.00	41.42	**18318409.20**	
Positive Behavioral Interventions and Support Services Total:							**6478916.40**
Positive Behavioral Interventions and Support Services	✓	houravg up/downsta	869	120.00	62.13	**6478916.40**	
Structured Day Program Services (SDP) Total:							**17360385.00**
Structured Day Program Services (SDP)	✓	houravg up/downsta	1637	525.00	20.20	**17360385.00**	
Substance Abuse Program Services Total:							**1298120.00**
Substance Abuse Program Services	✓	houravg up/downsta	92	415.00	34.00	**1298120.00**	

GRAND TOTAL:	**263063536.72**
Total: Services included in capitation:	54852794.28
Total: Services not included in capitation:	208210742.44
Total Estimated Unduplicated Participants:	**5132**
Factor D (Divide total by number of participants):	**51259.46**
Services included in capitation:	10688.39
Services not included in capitation:	40571.07
Average Length of Stay on the Waiver:	333